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ABSTRACT

This conference report presents issue papers that speak to the needs of minority group members with disabilities, solicited from human service professionals. The papers provide statistical data relating to the needs of various people with disabilities who are members of minority groups, describe initiatives developed to serve those needs, analyze the effectiveness of those initiatives, and offer recommendations for improved services. An introduction by Paul Leung and Tennyson J. Wright precedes the nine main topic papers of the conference, each of which is followed by "reaction" papers by one or more panelists. The topic papers are as follows: "Employment" (Alyce Earl Jenkins); "Research Needs Related to Minorities with Disabilities" (Paul Leung); "Mental Health and Minorities: Emerging Issues" (Timothy Summers); "The Vocational Rehabilitation of Minorities" (Frank L. Giles); "Prevention of Primary and Secondary Disabilities" (Julie Clay); "Empowerment and Minorities with Disabilities" (Eva P. Britt); "Minorities, Physical Health and Disability" (Anita Leal); "Substance Abuse and Disabilities among Minorities" (James G. Brown); and "Educational Needs of Minorities with Disabilities" (Frederick D. Bedell). Concurrent workshop reports are then provided, summarizing the issue papers and their recommendations on the issues of employment, research, rehabilitation, empowerment, physical health, and education; a final workshop sums up the discussions of the general session. A conference program and a list of program participants conclude the document. (JDD)

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THE UNIQUE NEEDS OF MINORITIES WITH DISABILITIES: SETTING AN AGENDA FOR THE FUTURE

Conference Proceedings

Co-Sponsored by

The National Council on Disability

and

Jackson State University
Jackson, Mississippi

May 6-7, 1992

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Edited by

Tennyson J. Wright, Ph.D. and Paul Leung, Ph.D.

Table of Contents

	Page
The National Council on Disability	i
Conference Planning Committee	ii
Acknowledgements	iii
Executive Summary	v
Foreword	ix
Welcome: Herman B. Smith	xi
Greetings: Sandra Swift Parrino	xiii
Message: President George Bush	xv
Minorities with Disabilities: An Introduction	1
Employment	3
Panelists	22
Research	33
Panelists	45
Mental Health	55
Panelists	68
Rehabilitation	81
Panelists	98
Prevention of Primary and Secondary Disabilities	111
Panelists	118
Empowerment	125
Panelists	132
Physical Health	141
Panelists	160
Substance Abuse	165
Panelists	182
Education	191
Panelists	203
Reports from Workshop	211
Conference Program	231
List of Participants	249

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Dr. Paul Leung

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The National Council on Disability and Jackson State University wish to extend sincerest appreciation to the faculty, staff, and students in the Department of Special Education and Rehabilitative Services, particularly Dr. Celestine Jefferson, whose support made this Conference possible. In addition, thanks are extended to the authors, panelists, workshop moderators, workshop recorders, and participants.

Executive Summary

The National Council on Disability, recognizing the neglect and disadvantagement of minority persons with disabilities, convened a Conference on May 6-7, 1992 at Jackson State University, Jackson, MS, with the theme "Addressing the Unique Needs of Minorities with Disabilities: Setting An Agenda for the Future." Papers were commissioned related to topics of concern which have impact on minority persons with disabilities. The papers addressed employment, research, mental health, rehabilitation, prevention, empowerment, physical health, substance abuse, and education. Reactors to the papers were also recruited from persons with disabilities, service providers, academicians, and government officials. A total of 186 persons, a majority from minority backgrounds, participated in the Conference.

Recommendations

The proceedings of the Conference, both in the commissioned papers on specific topics, as well as the responses of the reactors, contained recommendations which were particularly complementary. While specific consensus was not sought, there was considerable overlap between the recommendations suggested by all participants, adding not only to the credibility, but to an urgency for action.

The following recommendations are a synthesis of the many specific recommendations found throughout the proceedings. They are essentially based upon an assumption that government programs should target and focus on those within American society who often have the least and need the most.

1. Federal, state and local agencies need to recognize that the issues involving persons who are of minority status and who have disabilities are complex, and require coordinated attention of many different governmental programs and the competencies of professionals from many different disciplines.

2. As persons of minority backgrounds with disabilities are more "at risk", have less personal and family resources, have less knowledge and understanding of externally available resources, and fare less well socio-economically than minorities without disabilities, policies must be established which prioritize their inclusion in existing governmental programs.

3. Because there has been limited research related to minority ethnic/racial persons with disabilities, funding should be provided which will follow development of targeted research for these populations, along with policies which include minorities with disabilities in all disability and rehabilitation

related research.

4. Service delivery systems, including the state/federal vocational rehabilitation program, should have staff sufficiently educated and trained to work with multicultural populations, as well as an outreach effort that will ensure the participation of minority persons with disabilities.

5. Efforts should be made to address directly issues that affect minority persons and the prevention of disabilitiy, including the effects of racism, violence, substance abuse, and poor general health.

6. The lack of data suggests the need to develop and implement a data set sufficiently descriptive to assess incidence and prevalence of disabilities, and the impact of intervention among all minority populations, regardless of size.

7. Education continues to be important for minority persons with disabilities to achieve success. Policies and programs need to be developed and implemented to change educational systems to be more positive and less negative, focusing instead on the abilities of children with disabilities. Inclusion of minority children with disabilities into education, provision of adequate academic accommodations and support through mentoring activities, with sensitivity of educational personnel, will ensure that minority persons with disabilities will be able to participate as full members in the workforce of the future.

8. While the ADA holds much promise for persons of minority background who have disabilities, specific efforts must be made for outreach, education, along with needed resources to assist in removing barriers. A shift in federal resources targeted for those populations is needed.

9. The development of local grassroots networks connected to more formal regional and national networks for the dissemination of new information and technology, along with the establishment of a funded pool of resources, is needed to assist minority persons with disabilities to gain access to these resources.

Recommendations for the Council

As the primary sponsor of the Conference, the following recommendations specifically target actions related to minority persons with disabilities for the National Council on Disabilitiy to consider:

1. Establish policy that all programs of the Council will include perspectives of minority populations.

2. Develop and implement a national task force on minority populations with disabilities to assist in the review of ongoing and prospective Council programs and activities.

3. Collaborate with NIDRR and RSA, as well as other federal programs related to disabilities, to insure that attention is given to minority populations with disabilities in their respective policies and activities.

4. Maintain liaison with national minority organizations (e.g., National Urban League, NAACP) for advice, as well as outreach towards minority populations with disabilities.

5. Initiate national and regional meetings to increase awareness of disability issues, particularly ADA, with minority organizations and their constituencies.

6. Continue to hold forums addressing disability issues affecting minority populations in accessible locales for minority persons with disabilities.

7. Examine and establish relationships with other federal agencies and programs which affect minority populations with disabilities, such as the Census Bureau, various NIH programs, etc., to ensure adequate and appropriate data to assess need and impact of service delivery programs.

8. Monitor progress within the federal structure to insure the participation of persons of minority background with disabilities in all aspects of federal policy and programming.

9. Model the outreach process toward minority populations with disabilities using bilingual and alternative dissemination documents.

Foreword

Forty-three million (43,000,000) Americans have one or more physical or mental disabilities. Moreover as the population grows older this number is more likely to increase.

Needless to say, individuals with disabilities who are members of ethnic, racial and or ethnic cultural groups frequently experience discrimination disproportionately in comparison to their White or European counterparts. The combination of disability and ethnicity, race and or cultural background often results in a double form of discrimination.

The Americans with Disabilities Act (ADA) is often viewed by the community (business and private) from a perspective of cost or burden imposed by accessibility requirements. There still exists a dilemma as to the promises of ADA for minorities particularly in light of the double form of discrimination noted above.

This issue is of such concern that The National Council of Disability (NCD), an independent federal agency, charged by Congress with addressing, analyzing and making recommendations on issues of public policy that affect people with disabilities began to focus attention on the unique needs of minorities with disabilities in the Summer of 1991. Subsequently, the Council collaborated with Jackson State University (an historically Black University) to sponsor a Conference with the theme - - "Addressing the Unique Needs of Minorities With Disabilities: Setting An Agenda For The Future".

Issues papers speaking to the needs of minorities with disabilities were solicited from human service professionals from around the country as a first step to gather information about the problems confronting minorities with disabilities. The Conference was held at Jackson State University in Jackson, Mississippi on May 6-7th, 1992 and was coordinated by the University's Department of Special Education and Rehabilitative Services. The two day Conference, which was open to the public, focused on major issues of importance to minorities with disabilities such as rehabilitation, prevention, employment, research, physical and mental health, violence, substance abuse and education.

As a result of the interest of the participants and the substance of the information presented, the Council is committed to advancing initiatives which will foster research and demonstration projects that affect minorities with disabilities.

This Conference proceedings is viewed as the first step in a series of initiatives that the Council will undertake over the next year to address the issues identified in this document.

National Council on Disability

Welcome

from

Dr. Herman B. Smith, Interim President
Jackson State University

I am pleased to welcome you to Jackson State University for this very important Conference. We are honored by your presence here today and most proud to have been selected as co-hosts of this national conference to address the unique needs of minorities with disabilities.

Inherent in Jackson State University's mission is the unrelenting pursuit of excellence in teaching, research and service. Jackson State has a unique opportunity and is uniquely equipped and located to direct its resources toward solving the problems of urban dwellers. As the urban university of Mississippi, we embrace the challenges issued by being one of this nation's foremost historically Black Colleges and Universities; by being the fourth largest institution of higher learning in Mississippi; and by being the only public institution of higher learning in the metropolitan area.

Through involvement in conferences like this, Jackson State is able to fulfill all facets of its unique mission.

Dr. Celestine Jefferson, Chairperson of Special Education and Rehabilitative Services at Jackson State is to be commended for her work in involving the University in this monumental effort to set an agenda for the future.

I must also extend thanks to Sandra Parrino, Chairperson of The National Council on Disability, for her willingness to involve Jackson State and her leadership in bringing this national conference to our campus, city and state.

Special thanks are in order for Mrs. Mary Ann Mobley Collins, Conference Co-Chairperson, who continues to be an outstanding ambassador for Mississippi. I have been blessed to hear her speak so eloquently and convincingly about this conference and about Jackson State.

I urge all conference participants, especially the human service professionals, students and others from the historically Black Colleges and Universities, to focus intently upon the major issues of importance to minorities with disabilities. It is our sincere wish that your sessions will openly address and analyze concerns and barriers which limit or prohibit the participation of minorities with disabilities from full and rewarding lives.

Our resources and services are available to you. We stand ready to make your visit to our campus productive.

Thank you and welcome to Jackson State University.

Greetings

from

Sandra Swift Parrino, Chairperson
National Council on Disability

Good morning. On behalf of the National Council on Disability, I would like to welcome you to this Conference on "The Unique Needs of Minorities with Disabilities." We are delighted to be co-hosting this Conference with Jackson State University, one of the nation's great historically Black universities. We are especially grateful to Dr. Celestine Jefferson, the Chairperson of the Department of Special Education and Rehabilitative Services here at Jackson State University, for her leadership in organizing this event.

The National Council on Disability is an independent federal agency comprised of 15 members who are appointed by the President and confirmed by the Senate. Our mandate is to advise the President and the Congress about issues of concern to people with disabilities. This legislation is familiar to all of you now; it is The Americans With Disabilities Act.

Considering "The Unique Needs of Minorities with Disabilities" is and has been a priority for the National Council for several years. This Conference represents one of many efforts that we have made to highlight minorities and to seek full inclusion for minorities in disability policy decision-making and development. Disability policy and disability politics are like other areas of domestic policy and politics in our nation -- they are dominated by the culture and values, yes, biases of the White middle class. Unless we make determined and targeted efforts to ensure the inclusion of minorities in the policy-making process, we will not have policies, we will not develop programs, that address their unique needs.

Too often, little consideration is given to the unique needs of African Americans, of Native Americans, of Asian Americans, of Hispanic Americans, of rural Americans. American people are a diverse people and while we are bound together by our identity as Americans, we are also bound together by our cultural diversity. As Americans, we want to celebrate our diversity.

People with disabilities who are also minorities face double discrimination and a double disadvantage in our society. The statistics tell us this. People of color who have disabilities are more likely to be poor in our society than people who are White and have disabilities. We are not sure why this is the case, but we can surmise that it is a cumulative effect of poorer health and poorer socio--economic status that puts minorities at greater risk of disability, and at greater risk of not receiving needed services if they do have a disability.

In February of this year, I went with my colleague on the National Council, Larry Brown, to testify before Congress about the importance of considering the Unique Needs of Minorities in Disability policies. We spoke before the House Subcommittee on Select Education, which is chaired by Major Owens, who is a Black American. We talked about the dual disadvantage and the unique challenges often encountered by minorities with disabilities. We questioned the lack of minority representation in disability service profession, such as Rehabilitation and Special Education, and the over-representation of minorities in the disability population. We proposed research priorities which would address issues unique to minorities. We found Congressman Owens to be receptive and eager to work with us in developing policies to ensure the inclusion of minority Americans.

This Conference we begin today represents a rich resource of ideas and recommendations which will guide the National Council as we continue to promote policies which will address the unique needs of minorities. We are particularly pleased, and think it particularly fitting, to be in partnership with Jackson State University for this Conference.

In closing, I would like to introduce to you the members of the National Council who are present today. If you would please stand when I call your name. They are:

* Mary Ann Mobley of Mississippi and California
* Ellis Bodron of Mississippi
* Kent Waldrep of Texas, the Vice Chairman of the Council
* Larry Brown of Washington, DC
* Jack Gannon of Ohio and Washington, DC
* George Oberle of Oklahoma, and
* Tony Flack of Connecticut.

I urge you to seek out our council members during the next two days and talk with them. Share your ideas and your views with them.

Again, welcome. I look forward to the next two days of exploration as we examine "The Unique Needs of Minorities with Disabilities" and consider "An Agenda for the Future."

Thank you.

Message

from

President George Bush
The White House
Washington, DC

I am pleased to extend greetings to everyone who has gathered in Jackson, Mississippi, for a Conference to address "The Unique Needs of Minorities with Disabilities: Setting an Agenda for the Future".

All Americans -- whether or not they are persons with disabilities or members of ethnic minorities -- want to live independent, productive lives. We want opportunities to reach our full potential and to be treated with fairness, decency, and respect. Government can, and must, support these aspirations. We have made a strong start toward that goal through the Americans with Disabilities Act.

This landmark legislation, which I signed into law in 1990, can be viewed as a declaration of independence for the 43 million Americans with disabilities. It provides tools to knock down the physical and social barriers that have separated Americans with disabilities from the freedoms that they could glimpse, yet could not enjoy. Additionally, it greatly expands the protections and basic civil rights of persons with disabilities. No doubt many of you are well aware of the law's provisions because you played a vital role in helping us to win its passage. The members of the National Council on Disability remained unswerving in their support, and I commend them for their devotion.

While we have begun to meet the challenge of equality for minorities and disabled persons, it will take all of us working together to insure full access to opportunity. This Conference can help to bring about a greater awareness of the rights and the assistance programs that are available to minorities with disabilities. I encourage you in the important work of carrying the message of hope and help to these citizens.

Barbara joins me in wishing you a productive and enjoyable Conference.

Minorities with Disabilities: An Introduction

Paul Leung, Ph.D
Tennyson J. Wright, Ph.D.

Minority populations in the United States can be defined or described in many different ways depending upon whether the emphasis is on race, ethnicity, or culture. For the purposes of these proceedings, the focus will be African Americans, Asian Americans, Native Americans, and Hispanic Americans.... A dramatic change during the last decade has been the tremendous growth of these minority populations in the U. S. The U. S. Census Bureau 1990 data indicated that there are 30 million African Americans -- an increase of 13.2% since 1980; 7.3 million Asian Americans -- an increase of 107.8%; 2.0 million Native Americans -- an increase of 37.9%; and 22.4 million Hispanic Americans -- an increase of 53%. In comparison, the White population grew just 6.0% since 1980. The projections into the year 2000 continue to be just as dramatic. For example, current minority populations in California are projected to become the majority by the turn of the Century.

It is logical to conclude that the number of persons from these minority populations with disabilities are increasing as well. The proportion of minority populations who incur disabling conditions will most likely increase at even faster rates because of the concurrent variables of economic, vocational, and health status which often place persons of minority backgrounds at risk for disability. However, there is a surprising lack of data on minority populations with disabilities. Most of the data available on minority populations with disabilities relates to African Americans. Some data are available for Hispanic Americans and Native Americans and almost none for Asian Americans.

Bowe (1992), using 1988 Census Bureau Current Population Survey data, reported that of the 2,512,000 Black (African American) working age adults with disabilities, 71.8% have severe disabilities. This compares with 52% of Whites with severe disabilities and 68% for Hispanic Americans. The only major prevalence study related to minorities (Asbury, Walker, Maholmes, Rackley, and White, 1991) pointed out that African Americans and Hispanics with disabilities had lower incomes and consistently lower educational levels than their White counterparts. These data, or lack of such, suggested the need for much more attention to minority populations with disabilities.

It should be noted that minority populations with disabilities have been ignored from at least two fronts. First, minority communities have been generally preoccupied with their own particular needs related to survival and agendas such as the elimination of discrimination and racism. Their members with disabliities have

not been a priority. Second, within the "disability community", minorities have not been an emphasis and service delivery to Americans with disabilities has been essentially a movement of the White majority. It may be safe to say that even the passage of the Americans with Disabilities Act (ADA) may not by itself have much impact upon minorities unless both the minority and majority communities become much more aware and sensitive to the minorities with disabilities within them.

The need to attend to minorities with disabilities comes about from several perspectives. As noted earlier, the numbers of minorities in the U.S. are increasing and will continue to increase. Persons with disabilities will more than likely come increasingly from minority populations. Persons of minority status with disabilities will no longer be the exception. Finally, the needs and future workforce of America will most likely be met not only by its diverse racial and ethnic populations but by persons within those populations who have disabilities. Minority persons with disabilities will impact positively on the America of the 21st Century.

This Conference and these proceedings are not a beginning. They are a continuation of a legacy of national, regional and local conferences which began in the 1960s and continue to bring issues confronting minorities with disabilities to the forefront of the political, social, economic and health care system of America. The nine topic areas were selected from a list of areas the planners believed to affect minority populations with disabilities more so than others. Each by itself has tremendous implications for persons of minority backgrounds and experiences who have disabilities. Each topic can also be seen under the umbrella of the ADA.

These papers are a rich source of data and information substantiating from very different perspectives some of the day to day concerns relating to persons with disabilities and who are also members of minority ethnic/racial populations. In addition, the papers contain some very practical solutions that can be utilized to improve the lives of persons with disabilities and to enable the empowerment process to occur.

Statistical data varies widely within the papers. Much of this variablility comes from the different sources used as well as the differences in definition. Certainly, they point to the need for better definitions and descriptors of disabilities among persons from minority populations.

Some of the papers use data that differs from the quantitative empirical paradigm in that the data are anecdotal and experiential. It should be noted that these papers reflect the reality of current knowledge along with the frustration many of the authors feel related to the issues of minority persons with disabilities.

EMPLOYMENT

Employment

Alyce Earl Jenkins, M.Ed., CRC
Associate Professor
College of Education and Human Services
Wright State University
Dayton, OH

Employment challenges for minorities with disabilities are extremely potent because of the implications associated with being both a minority and a person with a disability. Wright (1960), one of the earlier observers of the relationship between ethnicity, disability, and religious minority groups stated: "employment opportunities, particularly at the higher levels, are sharply limited," (p. 15) for this group. Wright (1988) refers to minorities with disabilities as experiencing a *double whammy* [italics added]. In addition, minority women with disabilities experience a triple jeopardy because of race, disability, and gender. Gliedman and Roth (1980) discussed the similarities of isolation, racism and prejudices experienced by persons who have both disabilities and minority status. Pape, Walker and Quinn (1983) further observed, "This additional status can compound the rehabilitation process as difficulties increase for this population in both magnitude and complexity," (p. 18). This paper will focus upon three areas: (a) disability and poverty issues as they impact employment opportunities for minorities with disabilities; (b) exclusionary employment practices as used by employers, labor unions, educational programs and public rehabilitation programs; and (c) recommendations which can be used to influence policy and legislation.

For the purposes of this paper, the term minorities includes African Americans, persons of Hispanic origin, American Indian/Alaska Natives, and Asian American/Pacific Islanders. The meaning of disability is one used in the Americans with Disabilities Act (PL 101-336): (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." (p. 4).

Prevalence of Disability

Bowe (1988) found that the 1988 Current Population Survey (CPS) data indicated that one in every 12 (8.6 %) or 13,420,000 non-institutionalized persons in the age range of 16-64 have a work disability. Bowe, in addressing these statistics, stated:

> If we look only at severely disabled persons, we find 9.9% of all 16-64 year old Blacks have severe disabilities, more than double the white rate of 4.1%. Examining it differently, of all severely disabled working-age adults, 24%, or nearly one quarter are Black. The rate of severe disability among persons of Hispanic origin was 5.6%; Hispanics constituted 12.6% of all severely disabled

persons of working age. Thus, more than one-third of all severely disabled working-age Americans are minority group members. (p. 13)

Asbury, Walker, Maholmes, Rackley, and White (1991) indicated that:

Several factors have been suggested as contributing to higher disability rates within minority populations. Among these are poor prenatal and perinatal care, nutrition and diet, an inaccessible health care system, greater risk for physical injury in terms of living conditions and types of employment situations and finally a lack of proper health care knowledge and education. (p. 2)

Specifically, Asbury's (1987) study looked at prevalence of disability among Native Americans, African Americans, Hispanic Americans, and Asian Americans. The study reported findings for three minority groups, African Americans, Hispanic Americans, with Native Americans and Asian Americans being grouped as other. The study of 122,859 persons from 59,569 households revealed that in comparison to whites, there is an "over representation of African-Americans and Hispanic Americans with chronic health conditions." The study also showed that the South had the highest proportion of African Americans in the four disability groups, i.e., chronic health conditions, language and sensory impairments, mental disorders, and nervous disorders. The West had the highest percent of Hispanic Americans with physical, language and sensory impairments.

Morgan, Guy, Lee, and Cellini (1986) reported that American Indians have realized a number of health improvements since 1950. However, Toubbeh (Cited in Morgan, 1986) recognized that while there has been decreased mortality for communicable diseases as well as for diseases of early infancy and congenital abnormalities, rates for accidents and mental health problems have been steadily increasing for Native Americans. The five leading causes of illness and disability on the Navajo reservation are:

1. accidents/poisoning/violence
2. heart/circulatory problems
3. mental illness/alcoholism
4. respiratory/digestive problems, and
5. complications of pregnancy.

The Dayton Daily News (March 26, 1992) reported that "death rates for teen-age Indians and Alaskan Natives are more than 1.5 times the rate for blacks and more than twice that of whites of the same age. About three-fourths of their deaths are accidents, killings, or suicides and many of the rest are from treatable diseases". (p. 4A)

This information is based upon a study of 14,000 Native American teens who were in seventh through twelfth grades located in or near reservations. One-fourth of the study participants were Navajo and the remainder were from 49 smaller tribes.

In addition, Joe (1990) indicated that diabetes and its secondary conditions

(vision loss, amputations and renal failure) are also a major health problem among many tribes. The Dayton Daily News (April 7, 1992) reported that the diabetes rates among Indians as: 43.4% for Pima Indians and 9.2% among non-Pima Indians. African Americans and persons of Hispanic origin were also reported having a high rate of incidence of diabetes.

Prevalence of Poverty

Asbury, C. A., Walker, S., Maholmes, V., Rackley, R., and White, S. (1991) suggested that "most ethic minority persons with a disability are at a high risk given that a larger percentage of this population fall at or below the poverty level." (p.48) Bowe (1990) noted that 28% of working age adults with disabilities at or below the poverty level. This is not surprising given that the 1988 CPS reported 14.2% of adults with work disabilities were also unemployed. Bowe (1990) reported that the median income of working adults with disabilities was $6,323 in 1987; thee mean was $9,364. Among severely disabled persons, the figures were $5,246 and $6,618 respectively". (p. 4) Bowe further observed:

> One in ten adults reported no income at all in 1987. These 1,362,000 16-64 year olds had neither earned nor unearned income; they depended upon family members or unrelated individuals for their full support. Among those reporting some income, about half received $6,000 or less. (p. 5)

Asbury, et al. (1991) also found the following regarding specific disabilities and family income of African-Americans, Hispanic Americans, and White Americans with disabilities.

Table 1
Specific Disabilities and Median Family Income of African Americans, Hispanic Americans, and White Americans with Disabilities

Disability	African-American	Hispanic	White
	Income	Income	Income
Chronic Health Condition	$10,000	$13,000	$19,000
Physical, Sensory & Language Impairments	10,80	16,500	22,050
Mental Disorders	10,500	13,500	16,600
Nervous Disorders	9,500	13,250	18,000

The study did not report family incomes for American Indians and Asian Americans. According to Joe (1991), American Indians/Alaska Natives with

disabilities are a minority within a minority. Only 1.4 million persons in the United States identify themselves as American Indians or Alaska Natives. Morgan, Guy, Lee and Cellini (1986) found that:

> American Indians need rehabilitation services since they rank at the bottom of most statistical indicators of social success in the mainstream culture. For example, Indians have the *highest unemployment rate* [italics added], the lowest educational attainment, the lowest per capita income, and the poorest housing and transportation. (p. 25)

The poverty level of Asian Americans also appears to be under reported. Leung and Sakata (1988) cautioned against perpetuation of the stereotype that Asian Americans have made it. They indicated that:

> The poverty rates for Chinese, Korean and Vietnamese are considerably higher than for the white majority. Ten and a half percent of Chinese, 13.1% of Korean and 35% of Vietnamese are in poverty compared to 6.6% of the white population. (p.17)

The preceding literature review clearly indicates that minorities with disabilities are disproportionately represented for disability and poverty. These two factors, disability and poverty, directly impact the experiences minorities have in the employment arena. Wright (1990), Braddock and McPartland (1987) and McConnell (1990) found that lack of employment success is related to minority status, income level and disability. Walker (Cited in Asbury, et al., 1991) recognized that minorities with disabilities experience similar plights as other persons with disabilities. But, she added:

> There are special and unique problems that these individuals face because of [others] lack of awareness of their cultural differences. In addition, prejudice and racial discrimination continue to exclude a great number of nonwhite persons from full participation in all aspects of society. (p. 12)

The unique problems encountered by minorities with disabilities in securing and maintaining employment are often the result of exclusionary practices by decision makers and organizational systems such as employers, labor unions, educational systems, professional training programs and the rehabilitation services program.

Exclusionary Practices: Employers

Bowe (1990) stated that "few aspects of labor market economics are as discouraging as the figures on employment among all people with disabilities." (p. 2) Accepting the above statement, one can readily conclude that labor market economics are devastating for minorities with disabilities. An indication of the lack of employment value of persons with disabilities is evidenced by the omission of the reference to persons with disabilities from a list of factors reported by the Hudson Institute. According to the Hudson Institute (1987) report, *Workforce 2000-Work and*

Workers for the 21st Century, the following factors will impact the workforce:

* The population of the workforce will grow more slowly than at any time since the 1930's;
* The average age of the population and the workforce will rise, and the pool of young workers entering the labor market will shrink;
* More women will enter the workforce;
* Minorities will be a larger share of new entrants into the workforce;
* Immigrants will represent the largest share of the increase in the population and the workforce since the First World War.

However, there were omissions addressed by another Hudson Institute report in which Bolick and Nestlerath (1988) noted that while American businesses are responding to the projected increases of women and minorities in the workforce, persons with disabilities were being ignored. Bolick and Nestlerath suggested that:

> The disabled community is another potentially important, though often overlooked, source of capable new workers, a group particularly well suited to the economy's shift toward service occupations and away from physically demanding manufacturing jobs. According to firms who have hired them, persons with disabilities are more often than not highly safety conscious, reliable, loyal and motivated employees who perform well on the job and who tend to keep their jobs. (p. 102)

Harris (1986) reported that 66% of the working age people who were not employed said they wanted a job. Yet, Bowe (1990) indicated that while only 32% of working age (16-64) adults with disabilities work or actively seek employment, 22% of African Americans with disabilities were in the workforce while 23% of Hispanic Americans with disabilities were workforce participants. There seems to be evidence to support the contention that employers are overlooking a significant pool of potential employees who want to work. du Pont de Nemours & Company in Equal to the Task II, (1990), Scudder (Undated), and Russell (Cited in Jenkins and Amos, 1983), reported that persons with disabilities are quality employees. Why, the question is raised, are so many employers slow to take advantage of this valuable employment resource? Are employers victims of their own insidious employment barriers which they continuously perpetuate? What can employers do to achieve the goal of reducing unemployment and poverty levels for persons with disabilities?

Braddock's and McPartland's (1987) report on occupational opportunities for minorities has implications for minorities with disabilities who want to become employed. They surveyed 4,078 employers for four types of exclusionary barriers: "segregated networks at the candidate stage, information bias and statistical discrimination at the entry stage and closed internal markets at the promotion stage," (p. 5) Braddock and McPartland concluded that: a). segregated social networks constitute a racial barrier at the job candidate stage; b). white employers are suspicious of references for minority candidates from urban schools, minority clergy, minority businesses (they are more receptive from the Urban League or other

community groups); c). statistical discrimination or negative group stereotypes can result in a qualified minority job candidate being denied an equal opportunity; and d). closed internal labor market; i.e., informal or exclusive channels which are used for internal recruitment. The study also found that companies which had minority employees found it easier to recruit new qualified minorities. That is, they took advantage of minorities recruiting other minorities.

Given the similarities of attitudes that white employers have about minorities and persons with disabilities, it can be assumed that the aforementioned barriers also impede access to employment for minorities with disabilities. Minorities with disabilities usually lack a social network that is proactive in areas of employment. Further, they are penalized by discrimination from portrayals which are negative of minorities and persons with disabilities. Employers can increase employment opportunities for minorities with disabilities by using more objective means of collecting and appraising information about perspective employees. Currently employers rely too much upon informal methods of recruiting and promoting. Employer objectivity also means eliminating negative images about minorities and persons with disabilities. It seems that one practical method of influencing employer objectivity and improving their attitudes towards minorities and persons with disabilities would be to change the content of training programs for business students. Satcher and Henderson's (1991) study of personnel management students' acceptance of the Americans with Disabilities Act supports immersion of disability issues into business curricula at colleges and universities.

Exclusionary Practice: Labor Unions

As employers and labor unions have similar scope and boundaries, they also share common goals regarding productivity. However, it appears that during the past 25 years, labor unions have limited the participation of minorities and persons with disabilities. While employers have not been as compliant with Sections 503 and 504 of the 1973 Rehabilitation Act and affirmative action regulations as these protected groups desire, they have surpassed labor unions in this area. The discrepancy is puzzling since there is a strong labor-management partnership. Whitehead (1990) stated that labor leaders retort, "Unions don't hire." He observed that:

> . . . unions are found to have a strong influence in the hiring and other employment related actions through the collective bargaining process. Collective bargaining has been the key to gains achieved by labor unions over the decades and labor management cooperation has been a vital part of the outcome, even though some bargaining has been very aggressive and, at sometimes, negative. (p. 4)

It seems that if labor unions wanted to include persons with disabilities among their rank, contract language allowing hiring and transferring of persons with disabilities would have been incorporated long ago. Although Pati (1981) noted labor unions' reluctance to allow entry of persons with disabilities, he cited the early involvement of the Amalgamated Clothing and Textile Workers Union (ACTWU). In 1977,

ACTWU received a grant from the Rehabilitation Services Administration to test a service program for disabled employees and applicants. The goals of the program were to maintain injured workers, return former workers who left because of disability and to encourage the entry of disabled persons into unionized jobs. (p. 167) Bradford (1990) also has discussed labor union activities regarding employment of persons with disabilities. Among labor unions involved with disabilities are:

* International Association of Machinists Center for Administering Rehabilitation and Employment Services (IAM CARES)
* Human Resources Development Institute (HRDI) Handicapped Placement Program
* American Federation of State, County, and Municipal Employees (AFSCME)
* Communication Workers of America (CWA)
* United Auto Workers (UAW)
* Services Employers International Union (SEIU)

Nonetheless, Stubblefield (1991) acknowledged that labor unions do use exclusionary practices regarding persons with disabilities. He said:

> Labor unions have a tradition of representing the worker: we have historically fought for their rights, for safe and healthy work environments, and advocated for good jobs, good pay, and good benefits. That a role has always included assisting workers (union members) who had become disabled and were seeking to return to work. That special role has now expanded under recent policy changes to include helping people with disabilities make the initial entry to the job market. *ADA will further increase that involvement* [italics added]. (p. 1)

Since minorities are represented among the 17-18 million union workers, minorities with disabilities will also be beneficiaries of labor unions' recent commitment to recruiting and hiring persons with disabilities. In support of this observation, Whitehead (1990) indicated that:

> Getting into employment is a vital accomplishment. If and when employers are engaged in new hiring, and there are no laid-off union members or members with seniority interested in bidding for available positions, unions can promote the recruitment and hiring of persons with disabilities into union jobs. (p. 4)

In spite of labor unions' current receptiveness to employing persons with disabilities, Whitehead (1990) suggested that exclusionary practices may still be encountered because of labor union's fears regarding: weakening wage structures through use of the Fair Labor Standards Authority to pay subminimum wage; supported employment which might use a non-union member as job coach (such would be viewed as intrusion); outsourcing (subcontracting) to sheltered workshops; and restructuring jobs which could lead to renegotiation between the employer and

the union. Exclusionary practices may continue to make accessing apprenticeships difficult. Bradford (1990) also spoke of possible problem areas which are likely to be encountered regarding employing persons with disabilities. He stated that:

> There are also "permissive" and "illegal" areas wherein the law specifies what the union or employer may or may not collectively bargain. Areas such as hiring and advancement of people with disabilities falls in the "permissive areas of bargaining"; however, it could possibly be an illegal area that would prohibit bargaining on this subject matter depending on the circumstances. (p. 42)

Bradford further acknowledged that:

> Another area that frequently is pointed out as resistance by unions to cooperate with employers who are trying to assist people with disabilities is the unions refusal to abrogate or "bend the rules" pertinent to the seniority clause in collective bargaining. (p. 42)

Bradford suggested that much can be done to reduce current exclusionary practices by utilizing a memorandum of understanding rather than trying to change the collective bargaining agreement. It is encumbent upon rehabilitation practitioners, consumers, and other advocates to gain a working knowledge of labor unions and their practices. In addition, labor may need assistance in its efforts to become more aware of how it can achieve its goals of protecting its memberships rights while expanding employment opportunities for persons with disabilities. Perhaps a workshop for rehabilitation training faculty, consumers, advocates, labor union leaders, and employers would result in expediting the development of more employment opportunities for persons with disabilities, especially those who are of minority status.

Exclusionary Practices: Education

Over the years, education has always been thought of as one of the primary keys to employment success for minorities and persons with disabilities. Desegregation of school laws were seen as improving educational and job opportunities for African Americans. Enactment of Public Law 94-142 was seen as a vehicle for providing better educational opportunities for persons with disabilities. Yet, persons with disabilities are disproportionately represented in the under educated population. According to Bowe (1992), Hispanic Americans who are disabled are the least well educated of all groups studied. Morgan, et al. (1986) observed that Indians have the "lowest level of educational attainment." Bowe (1992) further indicated that the average African American with disabilities does not have a high school education; that only one in forty gradate from college. Leung and Sakata (1988) observed that while Asian Americans have the stereotype of excelling educationally, all is not as it seems to be.

Brolin and Gysberg (1989) emphasized the need for students with disabilities to participate in quality and relevant career education programs. Their review of the literature found that "the transition of students with disabilities from school to work is no better than it was in previous decades." (p. 155) They concluded "that students

with disabilities are not attaining greater vocational and independent living success than they did in previous years." (p. 158)

Persons with disabilities, including minorities with disabilities, have been short changed in both regular and special education programs. Transitional programs for students with disabilities are increasing, but often lack personnel and budgetary support. Given current financial cuts in education and human services, what little has been gained in transitioning students may be lost. Failure to provide quality relevant education to minorities and persons with disabilities will result in continued exclusion from the pool of people qualified to compete in the workforce by the year 2000. Minorities and persons with disabilities must be educationally prepared to respond to employment opportunities.

On the other hand, quality and appropriate education may not insure employment or may only yield under-employment. Taft (1983) in discussing employability of blacks who are deaf stated that:

> Traditionally, education has been perceived as a means to upward social and economic mobility for minorities. Yet, cases exist where black deaf college graduates were hired in laborer and service-type occupations by the institution conferring their degrees. Why must these black deaf college graduates make the choice of under-employment, public welfare support, or unemployment? (p. 456)

Elimination of exclusionary practices in education with resulting negative impacts upon employment of minorities with disabilities must occur. As the nation strives for improvements in all of its educational programs, attention must be given to the unique educational problems experienced by minorities with disabilities. It is imperative that any educational program modifications be monitored to insure that minorities with disabilities will realize educational equity.

Exclusionary Practices: Rehabilitation Services Program

In reviewing the literature regarding barriers encountered by minorities with disabilities in the areas of employment, education, labor unions, etc., there are similarities in those experiences and ones which are with public rehabilitation agencies. The similarities are striking because public rehabilitation programs are specifically charged with providing services to all persons with disabilities, and because public rehabilitation programs have espoused concern for minorities with disabilities for more than 38 years. Over the years, the Rehabilitation Services Administration (RSA) sponsored conferences (e.g., Alabama, Georgia, California, Mississippi) aimed toward increasing participation of minorities in pre-service training and service delivery. Indeed, it was in Jackson, Mississippi under the local stewardship of the late Dr. Darwin Johnson in 1980, that more than 100 participants listened to former RSA Commissioner Robert Humphreys (Cited in Johnson and Wen, 1980) state:

> First, it is generally and widely acknowledged that the incidence of disability among blacks and other minorities in this country is twice that of the white population. This means that *rather than providing services to these populations that coincide with their percentages of the population nation-wide, we should be increasing the level of service to twice that percentage.* Blacks in America represent 20% of the population. If Hispanics represent 5% and Native Americans and Asians represent 2 or 3% we should look to a goal of 40% of our services going to these populations, rather than the 25 to 30% that their population ratios reflect. (p.36)

It was here at Jackson State University that Dr. Bobbie Atkins discussed her dissertation findings regarding the delivery of services to minorities with disabilities. She later noted that:

> A large percentage of Black applicants were not accepted for service; of applicants accepted for service, a larger percentage of Black cases were closed without being rehabilitated; and Blacks whose cases were closed as "successfully rehabilitated were more likely than Whites to be in the lower income levels. (Atkins & Wright 1980, p. 42)

Atkins and Wright's (1980) study of Vocational Rehabilitation (VR) cases for fiscal year (FY) 1976 cases showed that 451,454 persons were in the VR system; 7.39% more Whites were rehabilitated than African Americans. During that same reporting period, more Black applicants (43,740 or 42.25%) than Whites (121,273 or 34.86%) were not rehabilitated. Comparing Atkins' and Wright's findings for FY 1976 with FY 1988 and 1989, the difference among Whites and Blacks who were rehabilitated in those years has grown considerably greater.

There were 62.7% and 63.3% more Whites with disabilities rehabilitated for the FY 1988 and FY 1989 than were minorities with disabilities respectively (RSA Information Memorandum 1988-89). The total number of all VR cases by race for 1989 was 607,919 with 78.4% White and 19.7% African Americans.

Although the data does not include all racial groups, it does seem that the number of minorities with disabilities who access and succeed in the VR system does not represent Bowe's findings that "more than one-third of all severely disabled working-age Americans are minority-group members," (p. 13). As Wilson stated (1986): "We are reminded that we still face problems in extending to ethnic minorities and culturally different persons the benefits of the rehabilitation system". (p. 55)

It seems that instead of a reduction and/or removal of exclusionary practices during the last few years, there has been an increase in factors which deny minorities equal access and success within the VR system. One can't help but wonder, "what's going on"; what is happening to minorities with disabilities? Ross and Biggi (1986) found in their study of non-white clients in the New York State Office of Vocational Rehabilitation (NYS/OVR) for 1982 and 1983 that:

> Whites made up a greater proportion of Status 26, or competitive closures, in 1983 while non-whites received a higher proportional representation than whites among those closed in non-rehabilitated closures (Statuses 28 and 30). (p. 40)

Ross and Biggi, like Atkins and Wright, found that the often reported reason for closing non-whites as not rehabilitated was "failure to cooperate." The primary reason given for whites was "refused services." (p. 35) Ross and Biggi further reported:

> . . . the non-white population within New York State and nationally shows that within New York State approximately 7.7% of all working age residents are disabled. ". . . black males represent 15.7% of all disabled males in the state of working age while black females comprise 21% of all disabled females between the ages of 16 and 64. One in eleven or 8.9% of all disabled working age New Yorkers is of Hispanic origin. Thus these two minority groups alone would comprise 45.6% of the total disabled population in New York State. (p. 40)

Of the persons served by NYS/OVR in 1983, 76% were white, 13% black, and 9% Hispanic. NYS/OVR reported serving 79% white, 19% black, Indian/Alaskan Native, 0.5%, and 19% other. Ross and Biggi concluded that NYS/OVR needed to do a better job of contacting non-white New Yorkers.

In addition to the exclusionary practices by state rehabilitation agencies, there are problems regarding representation of minorities among agency counselors. Jenkins (1989) found that little is known about the number of minority counselors employed by state-federal rehabilitation agencies. Her study found that 132 African American counselors were employed in Illinois, Minnesota, Indiana, Ohio, Connecticut, and the District of Columbia. Lawrence Johnson and Associates (1982) estimated that there were 12,000 rehabilitation counselors in 79 state agencies with no indication of the number of minority counselors. Ayers (1980) posed the following questions:

> In the field of rehabilitation, what are the latest statistics relative to the number of non-whites in a counselor or administrative position? How many non-whites are employed in both public and private rehabilitation agencies today? How many non-whites are presently enrolled in the 80-plus rehabilitation counselor education programs? (p. 7)

In addition to training and employing minority counselors, consideration must also be given to helping counselors develop the skills, interest, and attitudes which will facilitate relationships between white counselors and minorities with disabilities. There is much that needs to be known about this process. How many white counselors are influenced by the negative stereotypes of minorities? How many counselors are aware of culture specific techniques which can be used to increase access to and success in the state federal rehabilitation programs for minorities with

disabilities? How well are training programs addressing multicultural issues as recommended by the Commission on Rehabilitation Education? Humphreys (1980) expressed his concerns about the low representation of minority service providers within the VR system:

> . . .aside from the general lack of knowledge about rehabilitation on the part of minorities, especially in urban ghettos, barrios, and in rural areas. I hark back to the point Dr. Ayers made about the hostility and suspicion of non-white kids toward white educational institutions. Does not this hostility and suspicion carry over into the service delivery system? The VR system long has been regarded by minorities as lily-white. For the most part, it is. If we are going to attract minority clients to that system and if we are going to get them the services they so desperately need, we need a much higher proportion of rehabilitation professionals, counselors, supervisors, and administrators who are Black, Hispanic, Asian and Native American. (p. 36)

It seems that in spite of legislation (i.e., the 1973 Rehabilitation Act) and RSA initiatives, rehabilitation outcomes for minorities with disabilities remain the same as 12 years ago. How can we insure that ADA will be kinder and gentler to minorities with disabilities? How can we insure that more minorities enter the rehabilitation profession? How can we insure that non-minority counselors provide equitable services to minorities with disabilities? What can be done differently? Can we make the 21st Century brighter for minorities with disabilities?

Recommendations

We must establish an agenda for minorities with disabilities which will be multifaceted. Indeed, the interrelatedness of disability, poverty and under education dictate implementation of a multidisciplinary, intergovernmental and interagency approach to the problem. There must be a collaborative effort of health and human services, public education and employment programs to insure that minorities with disabilities access and experience success in all aspects of their lives. New legislation and policies may be appropriate solutions to some problems. However, there is a more pressing need to effectively implement existing rules and regulations; a need to hold public and private entities responsible for non-discriminatory delivery of mandated services. The activities of various government agencies must be monitored with the understanding that funding appropriations and personnel performance ratings will be determined by how well they provide services to minorities who have disabilities. Public and private agencies must be held financially accountable when mandates of ADA are not administered equally to white and minority persons with disabilities. The following are specific recommendations which should be considered when establishing the agenda for the future:

Employment/Labor Union

- Establish a Labor Union Advisory Board composed of retired labor leaders to develop strategies to address concerns regarding apprenticeships, supported employment, impact of subminimum wage upon wage structure, job

restructuring and effective use of memorandum of understanding to reduce existing barriers encountered by persons with disabilities. The Advisory Board would also develop an outreach program designed to assist minorities with disabilities to obtain/retain labor jobs and review existing labor laws governing unions to determine how they can be amended to accommodate persons with disabilities.

- Encourage the establishment of a national network of minority employees with disabilities. The network membership would consist of laborers and professionals who would serve as mentors for aspiring minority employees with disabilities. The group could share job leads, reduce feelings of isolation, be proactive on employment issues, etc.

- Encourage the Justice Department and the Federal Office of Compliance to publicize the names of employers who violate Sections 503/504 and ADA.

Education

- Develop amendments to PL94-142 which will insure that states provide children with severe disabilities relevant vocational services (i.e., career education, career counseling, cooperative work opportunities, vocational evaluation and vocational training). The services should occur in grades K-12 with special attention given to urban schools.

- Encourage colleges and universities to recruit minorities with disabilities.

- Mandate RSA to provide funding opportunities for colleges/schools of business to develop model curricula to teach their students how to work with and manage persons who have multiple disabilities.

- Encourage NIDRR to fund Historically Black Colleges and Universities to study specific disability issues within minority groups. For example, Jackson State University could become the "Center for the Study of Deafness among African Americans"; Morehouse College could look at diabetes among African Americans; a research center for disability issues among Hispanics could be established in Texas, etc.

Rehabilitation Services Program

- Establish a federal oversight committee for the RSA. The committee would be charged with policing RSA performance regarding the delivery of services to minorities. The group would be charged with insuring that RSA and all its state officers implement existing laws.

- Amend the next RSA Reauthorization Act to reward counselors for increasing access to VR for minorities with disabilities. Policy should also be implemented which will give additional closure credit for placement of minorities in quality

job slots.

- Develop a national outreach program to inform minorities with disabilities about rehabilitation services. Perhaps partnerships can be formed with the Urban League and national organizations which represent Hispanics, Native Americans and Asian Americans. The partnerships should also include the national offices of various religious denominations (i.e., Baptists, African Methodist, Episcopal, Nation of Islam, Pentecostal, Catholics, Episcopalians, etc.)

Other

- Revise National Council on Disability brochures to include special emphasis on issues pertaining to minorities with disabilities.

The above recommendations do not include suggestions which have been made over the years regarding recruiting more minorities for rehabilitation professions, culture specific counseling techniques, and disability awareness. Many of the older recommendations were only minimally implemented while many were simply forgotten. The future agenda for minorities with disabilities demands development of a strategic plan which will encompass old and new recommendations. The plan must include time lines and identify agencies/organizations responsible for implementation of recommendations which come within their governance. All parties must be committed to improving the quantity and quality of the delivery of services to minorities with disabilities. Professionals, agencies, and consumer organizations must be committed to eliminating the grossly inferior treatment of minorities with disabilities. The travesty must end before the year 2000.

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Reaction to Employment

Claudie Grant, Jr.
President's Committee on Employment of People with Disabilities
Washington, DC

The employment picture is grim for minority people with disabilities. Approximately 82% of all African-Americans with disabilities are unemployed and of the 18% that are employed, many are underemployed. Approximately 78% of all persons of Hispanic origin with disabilities are unemployed. Of the 22% of Hispanics with disabilities that are employed, many of them are also underemployed. We do not have any statistics on the employment rates for Native Americans and Asian-Pacific Americans with disabilities. However, it is believed that they also face a high rate of unemployment. All of us need to work together in order to eradicate this horrible unemployment nightmare.

People are talking about the empowerment of people with disabilities and that's fine. However, more than just lip service must be offered to such persons. In my estimation, empowerment gives one the opportunity to make choices. Employment is one of the most valuable ingredients in empowering people with disabilities in our society. Employment affords all of us the opportunity to make money and become somewhat financially secure; therefore, we need money. Often people in churches say we do not need money; we need God. However, I always respond; we need God and we need money too. Money is of immense value to all persons in our nation.

Recently several of my colleagues at the President's Committee made a presentation before the Business Roundtable which includes CEOs of the 200 largest companies in the United States. I understand that the Business Roundtable members accepted the presentation with great enthusiasm. A short video was shown at the meeting and my first question in our staff meeting was: "Were there any minority persons with disabilities in the videotape?" When the videotape was shown I was greatly pleased to see that minority individuals were included. I want Business Roundtable members to know that minority employees with disabilities want high-powered jobs. I am still waiting to get my first $200,000 a year job.

Companies and corporations need to seek out minority people with disabilities for employment opportunities. Many businesses say that they cannot find minority people with disabilities; however, there are a number of them who are well qualified. If the companies request my assistance I will gladly aid them in finding some people

and I will do it free of charge.

As Dr. Martin Luther King, Jr. would say (paraphrase) you may have the right to enter a restaurant; however, you need money to buy a meal. Today, you have the right to go in McDonald's but you still need money to buy a cheeseburger. Even after the ADA is fully implemented, people with disabilities will need money in order to fully enjoy and take advantage of their rights. Access to money does help to empower people.

Education is a key to obtaining employment opportunities for people with disabilities. We must stress that education is an important factor in empowering people with disabilities. Minority people with disabilities have a hard job securing employment even when they are well educated. Although we may have a tough time getting jobs, we must still continue to struggle for a good education. We must encourage all minority people with disabilities to get an education and to inform them about trade and business schools.

Rehabilitation agencies must try to be more responsive to clients' needs. Rehabilitation professionals must become more sensitive to the needs of minority individuals. Rehabilitation professionals ought to be schooled about the cultures of various minority people with disabilities. Counselors must deal effectively with their families. For example, Hispanic people are extremely family oriented. Also, counselors that are assigned to Hispanic areas should be familiar with the Spanish language. They should be familiar with Native American, Asian-Pacific American, and African-American customs and family traditions.

I am a product of rehabilitation and I am proud to tell you so. I am a former client of the Virginia Commission for the Visually Handicapped and I had a wonderful experience with that agency. Although I had all white male counselors, they were sensitive to my needs and pushed me to do my very best. At one point, I opted to go to graduate school and get a master's degree, although I really wanted to go to law school. My counselor refused to support me in pursuing graduate studies. My counselor said that I know that you want to go to law school and that you should not sell yourself short. I appreciate that counselor's efforts today. After getting my education, they, the Virginia Commission, assisted me in getting a job.

Let us help those who haven't had our advantages. Rehabilitation professionals, physicians, social workers, the National Council on Disability, the President's Committee on Employment of People with Disabilities, Jackson State University, the Howard University Research and Training Center and all of us should and must work together for empowerment of people with disabilities.

People with disabilities can and do want to work and we should not try to stifle their chances to do so. One day a lady called my office at the President's Committee and asked what type of jobs are impossible for persons with disabilities to handle and I thought for a second or two and responded there are no jobs that we can not do. We must not limit people and deter their progress. Again, let us

individually and collectively work to help others secure work. I close with a slogan that we use at the President's Committee, "It's good business to hire people with disabilities."

Reaction to Employment

Loran Graham
Michigan Department of Civil Service
Lansing, MI

Professor Alyce Jenkins cited many issues which impact negatively on the successful rehabilitation of minorities with disabilities in America. The proceedings of the National Conference "Future Frontiers in the Employment of Minority Persons with Disabilities" contain a number of papers which echo some of the same reasons over and over again. The fact that minorities with disabilities are seldom placed in nor have access to jobs at higher levels is cited and the finger points at employers, labor organizations, educational programs and public rehabilitation programs.

Professor Jenkins cited statistical data which shows that more than one third of all severely disabled working age Americans are minority group members. Yet the percentage of successful rehabilitations of minorities served shows a significantly high percentage of closures "Not Rehabilitated." Atkins and Wright's studies of vocational rehabilitation cases indicated that the most prevalent reason for closure for non-whites was "Failure to Cooperate." WHAT DOES FAILURE TO COOPERATE MEAN? It often means a lack of communication, a failure to understand the unique needs of minorities with disabilities, and an inadequate knowledge of the culture and subcultures that one presumes to deal with. Failure to cooperate most often indicates that minority persons with disabilities do not trust the rehabilitation system to improve the quality of their lives. It also means that counselors were not able to develop a trusting relationship.

The shortage of minority sensitive rehabilitation counselors is one of the prime reasons for the high failure of the system in the rehabilitation of minorities. In my 21 years of working in the employment area for and with persons with disabilities, I have seen many changes, helped to make some of them, and watched many practices that should have been eliminated continue.

Many of the significant changes made in the employment of persons with disabilities in the state of Michigan were made because of an enlightened administration in Michigan Rehabilitation Services, supportive governmental agencies, and the development of awareness among employers and labor organizations. Employment strategies were developed and counselors were provided with in-service training programs designed by Joyce Keener, President, of the National Association of Multi-cultural Rehabilitation Concerns, a Division of the National Rehabilitation Association and a forward thinking person named Dave

Molinaro. I was also fortunate enough to be a part of this team. The development of a strategy made it possible to create conditions amenable to the development of employment programs, agreements, and better job opportunities.

Most of our activities began in the Detroit Metropolitan Area and our client population included a large percentage of minorities with disabilities. In addition to the development of employment opportunities, we also worked cooperatively with clients and counselors in job placement. In order for us to be effective and to make proper job placement referrals it was necessary for us to obtain a good knowledge of the family situation and to sometimes deal with a multiplicity of family problems. One factor that we agreed upon - - persons with disabilities need good jobs with excellent fringe benefit packages. To accomplish this, it was necessary for our client to have the best training available and in areas which had jobs. Our initial assessment showed that far too many rehabilitations came about through the placement of clients in minimum wage jobs. For most clients, minimum wage jobs do not provide anything more than starvation wages. Most such jobs are devoid of benefits and pay little more than an individual can obtain through disability or public assistance programs. Good training and education does not lend itself to quick rehabilitation closures.

Services to minorities in rehabilitation are generally provided by majority counselors with middle to upper income values and life styles. These counselors, although well meaning, cannot possibly grasp the multiplicity of needs required for the successful rehabilitation of minority clients whether from a low income and culturally deprived background or on the cusp of middle income and potential affluence. There is as much of a chasm between them as there is land mass between the Mississippi River and the Atlantic Ocean.

One cannot say that minority counselors who have been reared in the upper lower or middle income environment, educated at schools which prepare them for the theoretically perfect rehabilitation setting provide minority clients with better service than majority counselors. How is it possible for this gap to be narrowed? One cannot understand the minority experience by attending a lecture, taking a course, or simulation. All of these may help to a small extent. The improvement of services to minorities with disabilities will require serious commitment and a substantial amount of time to achieve acceptable results.

A rethinking of current standards for successful closures and numbers may be a good starting point. There is also a push for short term closures while expending the minimum amount of money. Quality rehabilitation is seldom, if ever cheap. The rehabilitation of clients with multicultural backgrounds requires a number of things:

- Training for counselors on an ongoing basis. Inviting dialogue with minority organizations and inviting them to be a part of this training.

- Providing counselors with more time to build rapport with minority clients and to get to know the client's needs.

- More time in testing and selecting an evaluator who knows the proper test instruments to use and how to interpret the results.

- More time in working with minority clients in developing a rehabilitation plan and assessing the peripheral needs which may impact on the success of the plan. Make sure that support services, such as child care, are available if needed.

- Allowing time in the plan for remedial class work to strengthen the client in specific academic areas prior to initiating the training portion of the rehabilitation plan.

- Providing tutorial help at the first indication of an academic problem.

- More frequent follow up contact with clients.

- Conferences with the instructors.

Educational institutions must be made aware of the needs of minorities with disabilities and include appropriate course materials and instruction.

Rehabilitation agencies must interact more with businesses, labor unions, and employment agencies and provide them with information on their responsibilities under current legislation. Knowledge of labor contracts and providing both employers and labor organizations with technical assistance is a key method of gaining access to better employment opportunities for minorities with disabilities. Rehabilitation agencies must enter into a partnership with business and industry, and labor organizations. Outreach programs must be initiated with minority communities and the agencies that provide services to those in need of rehabilitation services.

The problems identified are many, the solutions are not simple, the place to start is here, the time to start is now.

Reaction to Employment

Daniel W. Wong, Ph.D.
San Jose State University
San Jose, CA

We are aware that the employment history of persons with disabilities, and particularly for those from minority groups, is disturbing, disheartening and remains the lowest in the United States.

While the number and diversity of types of persons with disabilities employed has increased during the last two decades, the actual percentage of the disability population from minority groups in the work force has decreased from about 41% in 1970 to about 33% in 1988. Forty-three million Americans with disabilities remain isolated, unemployed, and impoverished.

Persons with disabilities from minority groups represent the highest percentage from the American disability community of unemployed individuals of working age. This group falls at or below the poverty level. The most alarming information is that persons with disabilities from minority groups have success within the vocational rehabilitation system. It is critical to find a solution to this alarming reality. It will take strong and determined leadership to create and involve government, educators, private sectors, interest groups, and all citizens in the implementation of a national policy on disability, with emphasis on education and rehabilitation, and specifically on employment. This policy should encompass all aspects of disability and should embrace the diversity of all persons with disabilities.

In the past, we have tried to address these problems by planning, but no effective solutions or actions have been found or implemented. I believe that the time has come for us to be more proactive and aggressive in dealing with the issue of employment of persons with disabilities and more emphasis should be placed on the issues of employment affecting the minority disability community. This is the time to turn programs that foster dependency into programs that encourage advancement and productivity. Enabling persons with disabilities to be taxpayers instead of tax users will provide dramatic, immediate, and long term economic and life quality profit to government, to business, and to society.

Pioneering projects in areas such as rehabilitation education, special education, independent living, community access, supported employment, rehabilitation agency, projects with industry, and the utilization of new technology have clearly demonstrated the potential to integrate millions of previously dependent Americans with severe disabilities into the productive mainstream of society. In order to

continue this path and mission, there is a need to revitalize and expand existing programs to provide sound rehabilitation educational programs, vocational rehabilitation centers, independent living centers, rehabilitation technology centers, and other independence and productivity oriented services.

Although the 70's and 80's were decades of historic progress for disability related issues, this progress has largely taken the form of initiatives that demonstrated the potential for solutions, as opposed to solving the problems of disability on a society-wide and nation-wide basis. While the employment number and types of persons with disabilities have increased during the last two decades, the actual percentage of the disability population, and specifically those from minority groups in the work force, has decreased.

We have to be conscious of recent positive developments regarding the disability movement:

1. The recent enactment of the Americans with Disabilities Act (ADA) makes it unlawful to discriminate in employment against a qualified individual with a disability.

2. New technologies have paved the way for a significant expansion in the number and range of jobs that properly trained and equipped people with severely disabilities can undertake.

3. Educational programs and government agencies have become more sensitive toward the multi-cultural issues. Multi-cultural courses are becoming required courses in most human services graduate programs.

4. The concept of Education 2000 planning in various organizations have raised the sensitivity regarding the need for improvement in the educational system. It is time for us to become more involved in all levels of the educational transition to implement effective educational system for persons with disabilities from minority groups.

5. The majority of the persons with disabilities from minority groups are under the age of 35. It is during these years that individuals can achieve higher economic status and quality of life if they are provided proper rehabilitation services and are given the opportunity to participate.

We have to understand there is no single solution or panacea for this long and neglected problem. However, there are aspects we can improve in the service delivery system in order to provide better, effective, and meaningful services to persons with disabilities from minority groups.

1. Education

Obsolete and erroneous perceptions are a fundamental problem in this area; and education is the fundamental solution. Education is still the single most important pathway to employment for persons with disabilities from minority groups. We have to commit ourselves to prepare this population to be more competitive in the job market in the years to come.

We must encourage education not only for people with disabilities but for all Americans related to disability. All public and private school systems should cover disability issues in all curricula at all levels. Greater emphasis must be given to educating all individuals with disabilities to overcome the devastating effects of dependency and to develop the attitudes, habits, and skills for productivity which will enable them to become fully competitive and contributing participants in the mainstream of the society.

Persons with disabilities from minority groups must be provided sufficient educational training including degrees in technological fields and professional degrees at the graduate level. Moreover, they should be encouraged to pursue continuing education to upgrade their skills after they obtained employment. This action is critical for job tenure.

2. Rehabilitation options and flexible planning

Rehabilitation options should be clearly presented and persons with disabilities should have an active role in decision making and setting goals and objectives that will affect their future.

3. Vocational counseling, evaluation and placement

Greater emphasis must be placed on multi-cultural issues. Rehabilitation educational program must implement multi-cultural courses in vocational counseling, evaluation, and placement in their curricula. Continuing educational training in multi-cultural issues should be provided to rehabilitation facility administrators and practitioners. Rehabilitation professionals must be knowledgeable, sensitive, and respectful of the cultural backgrounds of the population they are trying to serve.

4. Examining the rehabilitation process

Greater emphasis should be placed on the holistic nature of rehabilitation. During rehabilitation clients should be educated about their disabilities in order for them to properly manage their limitations and the educational and vocational implications presented by their disabilities.

5. The involvement of family and the community

Although the quality of services provided by the rehabilitation professionals is critical, the family and community involvement and their participation is

indispensable. The support and participation of the client's family and the community in the rehabilitation process will ensure rehabilitation success among minorities.

Rehabilitation professionals should work closely with the client's family and the community to facilitate the educational and learning process of the family and the community with respect to disabilities and their vocational implications.

6. Networking

Policy makers, rehabilitation agencies, educational training programs, government agencies, advocacy groups, and national and local rehabilitation organizations should work closely together in order to share information on treatment, technology, and vocational opportunities.

7. Outreach and communication

Ongoing programs should be developed for reaching out and educating the community. These programs should be designed to inform persons with disabilities from minority groups of the availability of rehabilitation services in their immediate area. Multi-lingual literature should be developed to provide sufficient information. Multi-lingual information is also needed for action 503, 504, of the Rehabilitation Act and ADA.

8. Emphasis on abilities not disabilities

Improvement is needed for accurately analyzing job requirements and focusing on matching disabled individual's skills and abilities to potential job tasks. Maximizing their potential and enhancing their job tenure is the moral responsibility of every rehabilitation professional.

In summary, there is only one way to ensure the future rehabilitation success for persons with disabilities from minority groups and that is through education. In order to become qualified for competitive employment, this population must be vocationally trained and encouraged to pursue higher education. Furthermore, the family and the community should also participate in this educational process to facilitate transition in becoming productive members of society.

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RESEARCH

Research Needs Related to Minorities with Disabilities

Paul Leung, Ph.D.
University of Illinois @ Urbana-Champaign
Division of Rehabilitation Education Services
Champaign, IL

Introduction

The passage of the Americans with Disabilities Act (ADA) was a milestone in civil rights legislation for persons with disabilities and for Americans in general. It extended the promisee for full participation of Americans with disabilities in American society. The ADA is patterned after two civil rights laws - - namely, the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. There is no question that ADA is, at this time, only a promise. Even the Civil Rights Act of 1964 has not eliminated discrimination based upon racial status. It can only be assumed that full access and participation for persons with disabilities will be a long term process spanning several generations. There are significant numbers of Americans with disabilities who are members of racial/ethnic minorities, and their status is even more complex. Some have commented that this is a "double whammy" while others have suggested that "racism and handicapism" are connected by the common denominator of individual and institutional devaluation (Wilson, 1988). More significantly, for the purpose of this paper, the status of minorities with disabilities is essentially an unknown one.

Research related to cultural/ethnic/racial minority groups with disabilities is a specific need that has often not been addressed, and has often not been a priority within minority ethnic/racial communities especially among majority persons with disabilities. Both groups often have other significant agendas placing, by default, minority persons with disabilities on the back burner. The need for research is often problematic because of the way that research has been done in the past and because the results of research have not always directly impacted individuals. Racial/ethnic minorities know in very personal and intimate ways the status, situation, and problems often experienced by their members with disabilities and may not view further assessment of the needs to be necessary. Previous experiences with researchers have often been only related to the agenda of the researcher and results of research may not have been shared with those that participated. Certainly one aspect of research and needs assessment must involve developing trust and a commitment of the community. The objectives and rationale must not only be shared but developed and implemented with the community in question.

Sue, Arredondo, and McDavis (1992) have suggested that "white middle-class value systems are often reflected in counseling and social psychological research regarding racial and ethnic minorities." They further suggested that the three models which have served as guides for conceptualizing research on racial and linguistic minorities are particularly harmful. Sue et al. (1992) describe these models as the (a) inferiority or pathological model, (b) the genetically deficient model, and (c) the culturally deprived model.

Because much of research related to minority population began with these assumptions, the "underlying data and research base regarding racial and ethnic minorities have: (a) perpetuated a view that minorities are inherently pathological, (b) perpetuated racist research and counseling practices, and (c) provided an excuse for counseling professionals not to take social action to rectify inequities in the system. (Sue et al., 1992) The implications are clear that rehabilitation research of minority populations with disabilities must not contain similar bias. It is important that research related to American cultural/ethnic/racial minorities with disabilities reflect a positive base. The survival skills of the group suggest potential important contributions for rehabilitation.

Despite often recognition of the importance of research related to minority cultural/ethnic/racial populations with disabilities, there is very little follow through. For example, the draft of the research plan for the National Center for Medical Rehabilitation Research (1991) recognizes that the "influencing factors" to the rehabilitation process include cultural, ethnic, and gender diversity. The plan specifically indicated that "most of the conditions leading to restricted mobility disproportionately affect minority populations." (National Center for Medical Rehabilitation, 1991) However, little was found in the plan that specifically targets research with these populations..

Current Status of Research with Minorities and Disabilities

Atkins (1986) proposed during a 1984 conference the following researchable questions: Who are minority disabled consumers? What is the state of the art regarding research related to non-whites? What rehabilitation practices impact on success for minority disabled consumers?, and How can rehabilitation best recruit and retain non-white professionals?

Interestingly, Wright (1991) in testimony before the National Council on Disability offered among his recommendations the need for research related to the "breadth and scope of disability among racial-ethnic individuals with disabilities", "the status of inclusion and community based programs for racial-ethnic persons with disabilities", "the need for training to provide services which address the unique needs of racial-ethnic individuals", and the "methods and procedures to reduce the incidence of disability among racial-ethnic individuals." The point is, there has been

a lack of progress during this seven year span.

There has not been much research related to minority populations with disabilities. This is especially true for physical and sensory types of disabilities. One particular example related to the lack of data are publications such as the Disability Statistics Program at the University of California at San Francisco funded by the National Institute on Disability an Rehabilitation Research. The Disability Statistics Abstract for December, 1991, includes a table titled "Prevalence of activity limitations, 1989" which has race as one of the categories. However, race is divided into white, black, and other (included unknown). Other than the obvious question of who is included under other, what about Hispanics? Are they included under white?

One of the more comprehensive reviews of the literature was compiled by Wright and Emener (1989) as an annotated bibliography. The bibliography contained 526 entries across four minority populations -- Asian Americans, African Americans, Hispanic Americans, and Native Americans. In reviewing the contents of the entries, it was interesting to note that for Asian Americans, 20 of 83 involved disabilities other than mental health concerns. Of those 20, about one-fourth were related to epidemiological studies of stroke and hypertension. For African Americans, the majority of the entries were related to alcohol and mental health issues; 34 of the 168 entries were concerned with general disability concerns. Similar patterns were noted for Hispanic Americans where 14 of 76 entries were related to general disabilities, and for Native Americans, 12 of 196. A recent bibliographic series (1986-1988) by the Native American Research and Training Center further highlights the lack of data and models of services to Native Americans with disabilities.

The President's Committee on Employment of People with Disabilities recently released summaries entitled Black Adults with Disabilities: A Portrait, and Disabled Adults of Hispanic Origin: A Portrait based on the 1988 Census Bureau Current Population Survey (Bowe, 1992). Neither Native Americans nor Americans of Asian descent were reported. Their absence may have been due to their small numbers within the Current Population Survey and the sampling techniques used by the Census Bureau. Thus, even the most visible organization charged with gathering data on the U.S. population is not able to provide the data related to large segments of the minority population.

However, the data presented by Bowe (1992) provides an interesting beginning for exploring research related to racial/ethnic/cultural populations with disabilities. Bowe's work suggests that much more research is needed to address issues concerning minority populations with disabilities. Both Blacks (13.7%) and Hispanics (8.2%) have higher percentages of work related disabilities than Whites (7.9%). Further, 71.8% of Black working age adults with disabilities were severely disabled in contrast to 52% of Whites. For Hispanics, the number of adults with disabilities has grown by 31% in seven years. The absence of similar profiles for minority

populations, other than from African Americans and Hispanic Americans, suggests the need for even relatively simple demographic studies.

While there are 41 research and training (R&T) centers funded by NIDRR, the bulk of research related to cultural/ethnic/racial minority populations with disabilities has been done by four centers: (1) Howard University, (2) the University of Hawaii, (3) Northern Arizona University, and (4) the University of Arizona. Less than 10% of the research and training efforts have been targeted by NIDRR for study of minority populations. Two large constituencies are not represented by the present research and training centers - - Hispanic Americans and Asian Americans.

The R&T Center at Howard University has perhaps the broadest mandate in its attempts to generally approach all cultural/ethnic/racial groups with particular emphasis on groups that are economically disadvantaged. Among its research projects was one which addressed disability prevalence and demographic association among race/ethnic minority populations. Using data form the National Health Interview Survey (NIHS), Asbury, Walker, Maholmes, Rackley, and White (1991) specifically explored disability rates among minority populations according to geographic region, types of disability and demographic characteristics (e.g., age, family, income, sex, marital status, education and employment). Asbury et al., (1991) noted that this study focused primarily on African Americans and Hispanics. The investigators further noted the lack of information related to Asian Americans and other underrepresented groups. Some of the major findings of the Asbury et al., (1991) study suggested that African Americans and Hispanics with disabilities had lower incomes and consistently lower educational levels than their White counterparts. A high proportion of minorities with disabilities live in the Southern region of the U. S. Of that group, especially notable was the presence of 50% African Americans with disabilities. Similarly, a high concentration of Hispanics with disabilities resided in the West. Another interesting finding was the higher proportion of Whites with physical, sensory, and language impairments who were over age 65. Asbury et al., (1991) attributed this to better health care and greater longevity among Whites as compared to other racial/ethnic groups.

Other research of the Howard University R&T Center has included examination of attitudinal barriers contributing to the use of rehabilitation services, the sociological and psychological variables which facilitate career and employment success, the prevalence of depression and suicide among economically disadvantaged children and youth, the impact of substance abuse on the health and socioeconomic status, the identification of factors which enable families to effectively cope in minority communities, and a model for enhancing employment success.

The research program at the American Indian Rehabilitation R&T Center at Northern Arizona University has developed four core areas of research related to Native Americans . The core areas include research related to: (a) job development

and model job training, (b) exploration of culturally sensitive rehabilitation strategies, (c) community systems and consumer involvement, and (d) specific types of disabilities of significant concern to American Indian people such as learning disabilities, alcohol and substance abuse disorders. An interesting study done by the American Indian Rehabilitation R&T Center suggests the possibilities that may occur with ethnic/cultural/racial appropriate models. The study involved the utilization of genograms and eco-maps to assess American Indian families who have a member with a disability. The outcomes involved training vocational rehabilitation counselors in the use of genograms and eco-maps as family assessment tools. These have implication for improving not only rehabilitation for Native American people but for all groups including the majority.

The third NIDRR funded R&T Center at the University of Hawaii at Manoa has addressed demographic population studies, including the physical disabilities in the Marshall Islands and Hawaii, preventable ocean related injuries, community based needs assessments in Hawaii, American Samoa, and the Republic of Palau, appropriate cost-effective service models related to selected groups in the context of island service systems, and culture and disability research in collaboration with island based agencies such as the Samoa VR program. It is important to note that while this R&T Center's research is significant and needed, these particular Pacific Island groups do not compare with the size of the majority of the Asian American population which is currently almost 3% of the U.S. population.

While the research of these R&T centers may be pilot in nature and conclusions somewhat tentative, their studies clearly indicate the possibilities of issues yet to be examined. The implications for the rehabilitation process are profound.

Current Knowledge

There is some hesitancy to describe this as an attempt to summarize what is currently known about minority ethnic/racial/cultural persons with disabilities. Part of the difficulty is that rehabilitation and disability research is not the province of one discipline but is found in a variety of disciplines. An attempt to summarize or to locate available studies would require significant funding and other resources. Second, there is no central clearinghouse or database that provides for disability or rehabilitation research related to these populations which would provide ready access to the current status of research related to minority populations with disabilities. Such a clearinghouse would also allow for better understanding of the current status related to minority cultural/ethnic/racial minorities with disabilities.

Demographic

The definition of the problem with regard to basic demographic information is

perhaps the most advanced in terms of information and data related to African Americans, Hispanics, and Native Americans. The problems of members of these populations who have disabilities have been documented to be significant with regard to their socioeconomic level, education, and other variables. However, there continues to be a need to examine, in much more detail, data relating to disability and rehabilitation for these groups and there is a wealth of data which has not been explored. For example, the Rehabilitation Services Administration (RSA) national data base has not been utilized to the extent possible. In addition, the current methodologies used in sampling need to be broadened to enable analysis of smaller units. Because of their relatively small numbers, data related to Asian Americans have been particular lacking. In addition, what data are available are often not particularly helpful in formulating planning strategies or intervention. Research into the demographics of disability among various cultural/ethnic/racial minority groups will greatly facilitate the ability of governmental and local agencies to develop policy and to implement appropriate intervention. The essence of rehabilitation is the individual and the environment. The ability to individualize an approach and process which allows for responses to the individual and the environment is paramount and will benefit the entire field of rehabilitation.

Access

The early work related to access to the VR program suggesed an underrepresentation of African Americans compared with Whites (Atkins, 1981). Further studies by Asbury, et al., (1991) and Walker, et al., (1991) suggested that there are complex issues including educational levels and lower socioeconomic status that interfere with access to rehabilitation. Graham (1992) suggested that not only must research with African Americans and White comparisons incorporate socioeconomic status in research designs to "disentangle race and social class effects" but that "it is just as important that race homogeneous studies not err in the direction of ignoring socioeconomic distinctions between African American subjects." In other words, differences within groups are a major lack of current research related to minority population studies. This is particularly true of minority groups with disabilities.

Studies done with regard to other human service programs may have application for improving access of the VR process to currently underserved groups. There is even less information related to access to the VR process for groups other than African Americans. However, there are issues which need clarification which can only come out through appropriate research. For example, with regard to Asian Americans, "common knowledge" is that they are reluctant as a group toward receiving government help. Yet, evidence suggest that "virtually all Southeast Asian refugees begin their American lives on welfare." (Fardner, Robey, & Smith, 1985) This raises questions related to Asian Americans lack of participation in rehabilitation programs which need to be answered. There is a need to investigate the process

and to be able to respond to the needs of all persons with disabilities. There is considerable anecdotal data related to the access of minority cultural/ethnic/racial populations to rehabilitation systems, but much less empirically applied data.

Assessment and Eligibility Issues

Testing and assessment of minority populations have been examined in numerous contexts and there is considerable data available. However, within the rehabilitation process, there is less data related to assessment and consequent eligibility and acceptance into rehabilitation. Examining data such as the RSA data related to persons found not eligible may provide important clues concerning eligibility and decision making for persons who are members of minority cultural/ethnic/racial groups and who have disabilities. There have been no systematic efforts to study these issues within the state/federal VR programs.

Culturally Specific Rehabilitation

As noted earlier, all of the R&T centers have focused their attention on the development of culturally specific rehabilitation models. Underlying their development is the assumption that current models are perhaps not as effective or appropriate for the rehabilitation of minority ethnic/racial/cultural minority populations. The suggested evidence thus far, which is not conclusive, is that minority populations with disabilities have not utilized the current system to the extent to which their representation in the general population would have anticipated.

At the same time, it should be noted that the contributions of culturally specific models may extend far beyond the particular group and result in models that more effectively serve all groups because of the individually appropriate nature of culturally specific models. Indeed, there is some evidence that attention to family and other support systems which have surfaced in research of minorities with disabilities may have implications for improving rehabilitation in general.

Another relatively recent initiative in rehabilitation is supported employment. Data reported by Wilson, O'Reilly, and Rusch (1991), suggested that minority populations needs may not be reflective of their participation in these programs. Again, the issue relates to whether employment related needs are being met by current programs. The answers are not discernable from current data.

All of the research presently available on minority cultural/ethnic/racial populations with disabilities raises questions and suggests the need for more definitive and substantive answers for policy, planning, and programs. The lack of research, especially within existing federally funded programs, points to a need for far ranging and extensive attention. The recent National Institutes of Health

initiatives (Palca, 1992) provide a possible model for rehabilitation programs.

Recommendations

1. Involve minority communities and persons with disabilities into the feedback loop with regard to creation of research, implementation of research, and interpretation of the findings of research.

2. Improve and increase data collection and the information data base related to cultural/ethnic/racial persons with disabilities including incorporation of such sampling techniques which would allow analysis of smaller populations in meaningful ways.

3. Specific research initiatives with focus on particular racial/ethnic//cultural populations should continue including establishing R&T centers for these populations. The R&T centers should, in addition to their research activities, be required to provide technical assistance to other funded projects.

4. Federally funded research projects related to persons with disabilities, including R&T centers, should be required to include underrepresented groups similar to requirements recently imposed by the National Institutes of Health on its grantees.

5. Develop and implement training and education for persons of cultural/ethnic/racial background in research related to disability and rehabilitation to enhance the research capability.

6. Much research related to minority cultural/ethnic/racial/populations with disabilities has been cross-sectional. There is need for longitudinal research to explore effects of rehabilitation and their impact on these various populations.

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Reaction to Research Needs Related to Minorities with Disabilities

Jean Farish, Rh.D.
Department of Special Education and Rehabilitative Services
Jackson State University
Jackson, MS

Progress toward a healthier America will depend substantially on improvements for populations that are high risk -- low income groups, ethnic minority groups and persons with disabilities. Individuals who are especially at high risk are ethnic minority persons with disabilities. The challenge is to develop knowledge and understanding to effectively and appropriately address the special needs and concerns for this group of people. Changing trends in population patterns require a new research agenda to address the mental, physical, social and economic disparities that exist among special populations (i.e. ethnic/minority persons with disabilities), the most compelling of which is socioeconomic. Higher proportions of ethnic minority persons have been characterized as being socially, economically and medically disadvantaged (Santiago, 1988).

Dr. Leung's paper addresses the research needs of ethnic/minority persons with disabilities. One of the concerns identified in his paper is that much of the research reflects negatively on the ethnic minority population. He noted that research has often not been a priority within the "minority ethnic/racial communities". Dr. Leung identified the need for a comprehensive needs assessment. My response presents specific research strategies to plan and facilitate cultural awareness and for programs to address the unique needs of ethnic minority persons with disabilities.

Ethnic/minority persons with disabilities must deal with their own personal attitudes toward self, race/ethnicity and disability. In addition to dealing with their own attitudes, they must cope with the attitudes of society at large and attitudes of their culture toward disability. Therefore, research is needed to understand the attitudes of ethnic/minority groups toward physical and mental disabilities, and the wide spectrum of adjustment issues with which ethnic/minority persons with disabilities must cope. The influence of cultural attitudes toward help-seeking behavior and an investigation of both external and internal coping strategies are research areas that could facilitate understanding by rehabilitation professionals and service providers.

Hispanics utilize informal resources in coping with psychological problems (United States Department of Health and Human Services, 1991). African Americans rely on informal networks to a greater degree. However, some may be more likely to seek care for mental health problems outside the formal mental health care system by turning to relatives and neighbors (Ramseur, 1991). Religion has historically played a powerful role in the life of the African American community and African American individuals (Ramseur, 1991). Dressler (Cited in Ramseur, 1991) studied the ability of the extended African American family to buffer stress. Those African Americans who perceived their kin to be supportive reported fewer symptoms of depression. Therefore, rehabilitation professionals and service providers must understand the extended family as a major support system. They must consider significant others in the persons life during decision making, and that making self-centered decisions may be difficult without regard to family. However, there was no buffering effect for economic problems.

Within each racial or ethnic category, significant sub-group differences exist. Research is needed to investigate the intra group differences and variations within ethnic minority groups (Lee, 1991), and cultural influences on career development and occupational choices (Jones, 1991). Dr. Leung indicated that Hispanics and African Americans represent more blue collar workers and have more work related injuries. Thus, research on the types of work-related injuries and disabling conditions resulting from those injuries and exposure to risks and hazardous working conditions could facilitate prevention strategies and rehabilitation needs.

Research should be conducted on mental and physical problems that are more culture-specific and within the culture group than gender specific problems. For example, high blood pressure is much more common among African Americans of both genders than the total population. Severe high blood pressure is present four times more often among African American males than White males. Poor nutrition, smoking, alcohol and drug abuse, and other risk factors appears more common among African Americans with low income (U.S. Dept. of Health & Human Services, 1991).

The issue of mental health in the African American community is a vital concern. Between the ages of 20 to 24 and older, the different social conditions many young African American adults face, particularly males, takes a relatively high toll in lives especially from homicide as well as disabling injuries (U.S. Department of Health & Human Services, 1991). A system of socioeconomic barriers severely blocks human growth and stimulates retreat from reality, through drugs, destruction of human dignity and self-respect. Victims of self-destruction, exhibit self-defeating attempts to survive in a society which systematically frustrates normal efforts for natural human growth (Jones, 1991).

Ethnic minority persons with disabilities continue to face economic and social discrimination which limits their career and educational progress. An assessment of environmental factors that affect discrimination among ethnic minority persons with disabilities is needed. Gochros (1966), Stikes (1972), and Grier and Cobbs (1972),

suggested that counseling should focus on the effects of discrimination immediately. Factors that inhibit education, training and employment (e.g., illiteracy, language/linguistic barriers, etc.) should be identified in order to facilitate access to these resources. Overall drug use and its consequences are more severely felt by minorities. Data from the National Hospital Discharge Survey for the period 1982 - 1986 indicated that minorities had much higher rates for mental disorder and alcoholism in all four years (U.S. Department of Health & Human Services, 1991).

Research demonstrates a strong association between prevalence of alcohol abuse/dependence and various indicators of socioeconomic status. In drug programs both African Americans and Hispanics are overrepresented in maintenance programs. This does not mean that minority treatment needs are adequately being met. Specific drugs are abused differently by race/ethnicity. This suggests differential treatment needs. Research data also show a high frequency of co-dependency among people with substance abuse problems (United States Department of Health & Human Services, 1991). Research on the effectiveness of therapeutic modalities and the development of interventions that are culture-specific is needed.

The independent living needs of the ethnic/minority geriatric population are not adequately being met. Age, health, communication barriers and socioeconomic problems further inhibit independent living. Inadequate treatment and service delivery ultimately results in higher levels of institutionalization.

Attitudes of service providers affect participation in and follow through with services. Sue and Sue (1990) contended that among the reasons why minority individuals underutilize and prematurely terminate counseling/therapy is the basic nature of the services themselves. The services are frequently antagonistic or inappropriate to the life experiences of the culturally different client. They lack sensitivity and understanding, and they are oppressive and discriminatory toward minority clients.

Research on the attitudes and experiences of service providers, and an assessment of ethnic minority persons, and participation in and follow through with services could provide information for in-service training and community networking. Faced with western medicine and a health care system that is unfamiliar, Americans of Asian and Pacific Island descent experience unique barriers to primary care. In addition to linguistic and cultural differences, financial problems beset many subgroups, especially recent immigrants and refugees (U.S. Dept. of Health & Human Services, 1991). Thus, research in this area is needed to assess ethnic minority persons with disabilities' perception of problems with access to service delivery, follow through with services, and their ability to use resources effectively.

More studies relevant to community needs are necessary in order for rehabilitation professionals and service providers to work closely with the community to maximize service delivery. Thus, there is a need for more field based research and community based prevention programs.

More research needs to be conducted by ethnic minority persons. Majority persons tend to view minority individuals as a negative deviation from the norm resulting in labeling, stigmatizing and negative attitudes when behavior is culturally different (Atkins, 1988). Many times we try to resocialize, correct, modify and rehabilitate those behaviors which are critical to the survival of individuals in various cultures (Akbar, 1991). Appropriate research methodologies are needed to address adequate sampling and data collection strategies. Research can be a powerful means of combating stereotypes and correcting biased studies (Sue & Sue, 1990).

A comprehensive needs assessment is recommended to meet the unique needs of ethnic minority persons with disabilities and to provide cultural awareness training. The thrust is integration, mainstreaming and empowerment of persons with disabilities. One of the major challenges is to improve our understanding of the needs of persons with disabilities by improving the effectiveness of data systems and the availability of data with which to set targets. Dr. Leung identified the need for a central clearinghouse or data base that provides rehabilitation research related to ethnic minorities. Most importantly, research results should be disseminated and used to implement proactive strategies to facilitate equitable service delivery and equal opportunities.

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Reaction to Research Needs Related to Minorities with Disabilities

Sylvia Walker, Ed.D.
Howard University
Washington, DC

While it is true that individuals with disabilities who are members of racial and ethnic minority groups and their families encounter the same challenges as other individuals with disabilities, these persons face special and unique problems because of socioeconomic, health, cultural, and other factors. In addition, prejudice, discrimination, and economic barriers continue to exclude a great number of minority persons and their families from full participation in all aspects of society. In many instances, access to health care facilities, community agencies, stores, schools, and transportation can only be acquired through the use of extreme measures. In addition, languages, cultural and attitudinal barriers impede access to needed resources. As a result of these circumstances, the minority person with a disability and his/her family frequently find themselves set aside from the mainstream of everyday life. The unique status of non-White persons with disabilities tends to compound their disability problems.

During the 1980's, increased numbers of minority families migrated to the United States from all corners of the globe. Included were minority and bilingual/bicultural families representing a wide array of customs, cultures, ethnic, and language groups. For example, the American Indian population represents approximately 511 independent nations. Hispanics in America exemplify a variety of cultures which are rooted in South and Central America, Mexico, and Puerto Rico. Asian Americans embody the cultures of Japan, China, Korea, and other heterogeneous groups whose values, mores, and customs are influenced by a number of variables including socioeconomic status, educational level, and geographic origin (Walker, Belgrave, Nicholls, & Turner, 1991); (Walker, Fowler, Nicholls, & Turner, 1988). Cultural differences within and among ethnic minority groups affect their attitudes toward disability as well as their expectation of rehabilitation outcomes (Wilson, 1988). Therefore, approaches to research and the provision of services must take into consideration a number of variables and creative strategies.

The implementation of research in minority communities has been especially challenging due to the following factors:

* All too often the research agenda is designed to meet the needs of the

researcher rather than the needs of minority communities.

* Research outcomes rarely reach consumers, service providers, and other relevant audiences within minority communities.
* Persons in minority communities have been excluded from the planning process with regard to the design of relevant research.
* Sampling techniques fail to facilitate the inclusion of diverse populations such as Asian Americans, and people of Caribbean descent.

Dr. Leung makes the point that it is essential that:

* Research and needs assessment must involve developing trust and commitment of the community.
* The objectives and rationale must not only be shared but developed and implemented with the community in question. (Leung, 1992, p.4)

The overwhelming preponderance of research focused on racial and ethnic minority groups has presented these persons from unrealistic and negative viewpoints.

The National Institute on Disability and Rehabilitation Research is to be applauded as it has been a primary source of funding relative to the implementation of research which focuses on the needs and capabilities of racial/ethnic persons with disabilities. Current research is being implemented by the American Indian Research and Training Center, Northern Arizona University, (602) 523-4791; Howard University Research and Training Center for Access to Rehabilitation and Economic Opportunity, Howard University, (202) 806-8727/28; Native American Research and Training Center - Improving Rehabilitation of American Indians, University of Arizona, (602) 621-5075; Pacific Basin Research and Training Center, University of Hawaii School of Medicine, (808) 948-8287.

The future for research which focuses on multicultural disability issues is much brighter than the past. This Conference, which is being sponsored by the National Council on Disability, is an encouraging landmark. A recent Conference sponsored by the Center for Child Development of the National Institutes of Health is also helping to lay the foundation for the expansion of research which focuses on issues and concerns relative to racial/ethnic persons with disabilities and their families. A number of research papers were presented which focused on ethnic groups which are frequently overlooked including: Asian Americans, Alaskans, and Pacific Islanders.

I agree strongly with Dr. Leung that the following are among the critical future research needs:

- There is a need for culturally specific research models which may result in more appropriately designed service delivery approaches.

- The need to involve minority communities and persons with

disabilities into the feedback loop with regard to creation of research, implementation, and interpretation of the findings of research.

- The need to expand the research capabilities of institutions of high education (including Historically Black Colleges and Universities) that have significant numbers of minority students.

As we approach the end of the 20th Century, people with disabilities (including those who are members of ethnic minority groups) ask for the opportunity to be recognized as human beings who have the capacity to love, share, create, work, live fruitful lives, and contribute to society. The challenge for America is to provide the environment for all persons with disabilities to do so. The passage of the Americans with Disabilities Act (ADA), and the development and implementation of appropriate, relevant, and creative approaches to rehabilitation are good foundations for America's success as we approach the 21st Century. There is a unique opportunity for persons with disabilities from minority communities and their families to join with researchers in order to set and appropriate research agenda, which will result in full participation in American life.

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MENTAL HEALTH

Mental Health and Minorities: Emerging Issues

Timothy Summers, M.D.
Jackson, MS

Mental health is a general term which refers to the absence of mental disorders but also to the ability of an individual to negotiate the daily challenges and social interactions of life without cognitive, emotional, or behavioral dysfunctions. In addition to socio-economic variables, mental health and mental disorders can be affected by other factors such as biologic and genetic vulnerabilities and acute or chronic physical dysfunctions.

It is estimated that 23 million adults living in communities in the United States are severely incapacitated from mental disorders. This does not include substance abuse which is almost twice that number. In 1980 mental disorders were conservatively estimated to cost the American public 73 billion dollars annually, about half of which reflected lost productivity.

Different estimates suggest that 10-12% of children and adolescents suffer from mental disorders such as autism, attention deficit disorders with hyperkinesis and depression. Mental disorders of adolescents including developmental delays, conduct disorders, and the associated cognitive, behavioral and emotional disabilities drastically shape life's course and outcome.

Suicide and homicide are the most serious outcome of mental disorders. Approximately 30,000 Americans each year take their lives; 5,000 Americans under age 25 take their own lives and mental illnesses are the major contributing factor. Schizophrenia affects approximately one percent of the adult population. Depression affects approximately five percent of the population at any given time.

Mental illness demographics are very different when one focuses on minorities. A minority, by definition is: A group characterized by a sense of separate identity and awareness of status apart from a lower group of which it forms or is built to form a part; a group differing from the predominate section of a larger group in one or more characterizations, such as ethnic background, culture, or religion and as a result are often subjected to differential treatment especially discrimination.

The racial/ethnic categories which constitute minorities in the U.S. are Native American, or Alaskan Native, Asian/Pacific Islanders, Black (not of Hispanic origin), and Hispanics (both white and non-white). The term Native American includes those referred to as American Indian, Eskimos, and Aluts from Alaska. This group made

up less than one percent of the U.S. population in 1980. This classification of Americans consists of sub-groups of various cultures (Sioux, Cherokee, etc.) Those grouped as Asian/Pacific Islanders made up one and one-half percent of the population in 1980. This group has significant differences in cultural heritage and varies considerably in the degree to which they are disadvantaged. Chinese and Japanese made up the bulk of this classification in the U.S. in 1980. Persons from this group are not as likely as persons from other Asian groups to exist below the poverty level. Approximately 11% of Chinese, 13.4% of Korean, and 35% of Vietnamese are in poverty. The Asian group, although heterogeneous, seems to have in common strong motivation for academic achievement, generational relationships and differ in their help seeking behavior.

Black Americans are the largest racial minority comprising approximately 12.5% of the U.S. population in 1987. Black Americans are those Americans of color who can trace some of their ancestry to the African Continent and then to the U. S. Over half of this group lives in the Southern U.S. and 37.1% finish high school. This is a heterogeneous group of varying social, economic, educational and religious backgrounds.

Hispanics are the largest ethnic minority population in the U.S. and comprised eight percent of the population in 1987. This is an ethnic rather than a racial group. Ninety-five percent of the members of this group are racially classified as White and 41% finish high school and 10.7% complete college. Hispanics comprise individuals of white, black, and American Indian origin and those of mixed social parentage. The characteristics which make up this varied population have in common the following: they either immigrated from or have ancestors from or have someone associated with countries that were under Spanish conquest, most are still Spanish speaking (first or second language). The largest sub-group of Hispanics is the Mexican Americans. Puerto Ricans and Cubans make up the second and third largest sub-groups respectively. Immigrants from Central and South America increased their number in the U.S. by 40% from January 1982 to 1987. Only 20% in 1987 completed high school and 8.6% completed college.

Minorities and Geo-Politics

The geo-political significance of the country of origin of many minorities frequently determines which minority designation one receives and how they are treated irrespective of skin color. Persons from oil rich pro-American, Saudi Arabia and cash rich Japan, fare far better in the U.S. than those who were brought to this country under duress or are immigrating from a country which is poor, Black or both. The country of one's origin can be an advantage or disadvantage depending on the state of global geo-political or economic status at any given time.

Of the four minority groups, African (Blacks) Americans were the only

minority group in which its members did not come to the U.S. voluntarily. They did not bring their culture, language, religion, economic resources or family unit as a unit, nor were they seeking better opportunities or fleeing from adversity as many other minorities.

Race -- descendant from a common ancestry

Members of minority groups perceive themselves as different from the majority group and they are perceived as being different by whites. These perceived differences, the historical context of the groups' interactions, and their place in economic history have resulted in a complexity of feelings, attitudes and perceptions. These differences often have resulted in differential treatment which permeates the U.S. and its institutions including the mental health system. One of the most frequent forms of differential treatment is discrimination which affects people with and without disabilities.

Being a minority in the U.S. generally has varying levels of significance. For ethnic minorities, many of whose group members are White, the impact may be minimal. For racial minorities who are Black, the impact generally affects many areas of their lives, (i.e., education attained, income level, employment, mental health and overall quality of life.)

Health Status and Ethnicity Race

Health status has been associated with income status, educational attainment, race or ethnicity. In general, health status is directly related to advantaged or disadvantaged status. Disadvantaged status is almost synonymous with poor health. Disadvantaged status often is related to low income, high ratio of unemployment, and lower moderate health insurance coverage.

In the U.S., the predominant form of health care service is the fee for service system. Obviously, the ability to pay for health care services is of valuable importance to one's ability to enter the health care service system. It is estimated that between 31 and 40 million Americans are without any form of health insurance and have only a limited ability to pay for needed health care service. The out-of-pocket cost for health care in the U.S. is among the highest in the world.

Blacks, Hispanics and Native Americans have higher birth rates. A proportionally younger population and a high proportion of their members live below poverty level. They also have lower median incomes and lower educational levels than Whites. Data on Blacks and Hispanics show that they have higher unemployment levels, a higher percentage of single headed households and a lower level of property ownerships than Whites. Asian Americans in contrast have a higher proportionate level of income and education than the White majority.

The health impact of being a Black or Hispanic minority is striking. Blacks have higher mortality rates than Whites for most of the leading causes of death including heart disease, strokes, cancer, and homicides for which the rate is six times higher for Blacks.

The death rate among American Indians for all causes is essentially the same for Whites. American Indians have a higher rate of alcoholism related deaths (at younger ages) from liver disease and cirrhosis. Diabetes is also a problem.

Other socio-economic variables which impact health on life-span and health include marriage, divorce, and birth rate. Life expectancy was higher for Whites (75.4 years) than Blacks (69.4 years) in 1986. The percentage of Blacks currently married is lower than for Whites and the divorce rate is much higher for Blacks. For Hispanics, the percentage married is declining, but it continues to be much higher than Blacks and closer to that of Whites.

The relevance of who is working and who is not working for Blacks and Whites is significant. The unemployment rate among Whites is 5.5%, Hispanics is 8.8% and Blacks is 13.0%. Blacks are more than twice as likely as Whites to be unemployed. White families with a working husband and wife who are college educated have a median combined income of $57,068. Nearly one-third of all Black families in 1987 were headed by a female, single head of household, with no spouse present and female children under age 18 compared to 7.4% for Whites and 16.6% for Hispanics. For all groups living below the poverty level, the highest incident is for children under 16. After all races are considered, poverty is highest in the South and among Blacks.

Health status is directly related to socio-economic status. In the U.S., socio-economic status is strongly influenced by the racial or ethnic group to which one is a member. Negative implications of one's racial or ethnic grouping seems to be strongly influenced by skin color and whether or not one is an African-American or non-White Hispanic.

There is limited data which suggests that the prevalence of some mental disorders varies by racial and ethnic groups. It is also known that socio-economic factors have a strong influence. As socio-economic status rises, rates of currently active mental disorders decline within all ages. Those in the lowest socio-economic status have a greater risk of having a mental disorder than those in the upper socio-economic status. Socio-economic status is significantly related to rates of schizophrenia, and cognitive disorders.

Blacks

Examining the lifetime prevalence of illicit drugs indicates that Blacks are

significantly more likely to have used crack and heroin than Whites. Since Blacks are more likely to live in the inner cities, they are more at risk for drug abuse. However, the spread of drugs to rural and suburban communities is rapidly increasing. Blacks, and to a lesser extent Hispanics, seem more likely to use cocaine and to use several drugs in combination with potentially fatal consequences. It is however, accurate to say that polydrug abuse for all citizens who abuse drugs is more the norm than the exception.

Age-specific racial differences exist in lifetime prevalence of alcohol abuse/dependency. Younger Blacks are less frequent to have histories of alcohol abuse/dependency than younger Whites, while middle-aged and older Blacks have higher rates than their White counterparts. More than 71% of Hispanic women abstain or drink only infrequently, compared to 62% of Black women and 53% of White women. The rate of liver cirrhosis among Blacks is double that of Whites nationwide and in some cities is as high as 10 times the rate of Whites. Blacks and Hispanics are over-represented among alcohol-related deaths and among those arrested for drunken-driving and in alcoholism treatment programs.

Estimates from the 1981 Epidemiologic Catchment Area (ECA) East Baltimore Survey suggested that mental health facilities are meeting the needs of Blacks less frequently than those of Whites; 53% of minorities had unmet mental health needs in contrast to 44% of Whites. Blacks and Native Americans/Alaskan Natives were heavily over-represented among clients in social detoxification programs. These programs are generally located in a specialized non-medical facility with physician services available as needed. Blacks and Hispanics are over-represented in maintenance programs in which methadone or other approved drugs are administered at relatively stable dosage levels as a substitute for opiates. The population-based community estimates, from the five sites included in the Epidemiologic Catchment Area program (ECA) study of 1980-82, do not indicate significant differences between Blacks and Whites in overall prevalence of mental disorders with one exception: Black respondents had higher rates of phobias. Both Blacks and Hispanics are less likely than non-Hispanic Whites to use specialized mental health care services, even when they have been diagnosed as having a mental disorder or have defined themselves as having a personal problem.

Blacks are more likely than Whites to be diagnosed as having Paranoid Schizophrenic Disorder and less likely to be diagnosed as having affective disorders such as depression, although subsequent re-diagnosis with trained research teams tends to eliminate these differences. Examining lifetime prevalence for specific disorders by race for their ECA sites (New Haven, Baltimore, and St. Louis), revealed only slight racial differences between Blacks and all others. Blacks had significant higher rates of simple phobia than others in Baltimore (27.6% vs. 17.4%) and in St. Louis (11.1% vs. 5.9%). Prevalence of agoraphobia was nearly twice as high for Blacks as for others in Baltimore (13.4% vs 7.2%). Blacks had higher levels of

psychological distress than Whites, while the same was not true at higher stress levels.

Hispanics

Data from the Los Angeles ECA Survey suggested relatively few differences in prevalence of mental disorders between Mexican Americans and non-Hispanic Whites, with the exception of major depressive episodes which were much more prevalent among non-Hispanic Whites. With respect to alcohol consumption, Hispanic males had higher rates of alcohol abuse/dependency than either non-Hispanic Black males in all ECA sites. Hispanic women had rates equal to or lower than those of non-Hispanic White women or non-Hispanic Black women for these alcohol related disorders. Data from both the National Drug and Alcohol Treatment Unit Survey (NDATUS) and the Drug Abuse Warning Network (DAWN), suggested that drug abuse/dependency is a particularly serious problem among minorities, especially Blacks, and that cocaine (including crack) has a prominent role in drug-related deaths for both Blacks and Hispanics. Blacks and Hispanics are more heavily represented among drug treatment program admissions than among alcohol treatment program admissions in specialized facilities. Hispanics are about as likely as non-Hispanic Whites to be admitted to state or county mental hospitals, and less likely to be admitted to any other kinds of facilities, such as private psychiatric hospitals.

A recent review of the literature on the epidemiology of mental disorders among Hispanics indicated that studies are inconsistent in their findings. Some studies indicate higher prevalence of mental disorders among Hispanics than among non-Hispanics, but others suggest few differences between the two groups. Research using the DIS tends to report similar prevalence rates for Hispanics and non-Hispanics for a limited number of DSM-III diagnoses, while data relying upon reports of psychiatric symptoms support the claim that mental disorders are more common in Hispanic populations. ECA data from the Los Angeles site showed a significant difference for only one disorder between Mexican Americans and non-Hispanic Whites - major depressive episodes, which was more prevalent among non-Hispanic Whites. Desegregating that data by sex and age showed that for non-Hispanic White males, the lifetime prevalence rate for DIS disorder decreases significantly (to 28%) after age 40. This is not the case for Mexican American males whose rate is 35.7% after age 40. Non-Hispanic White women under 40 report a 50% higher lifetime prevalence rate for any DIS disorder compared to their Mexican American counterparts; among 40 and over, however, non-Hispanic Whites have rates that are 30% lower than those of Mexican Americans.

With drug abuse/dependency the only notable difference, non-Hispanic Whites had lower rates of severe cognitive impairment than did Mexican Americans. It should be noted that non--Hispanic Whites in Los Angeles had lower rates of

severe cognitive impairment than the total rates at each of the four other ECA sites. A related consideration in accessing the mental health of Hispanic Americans is the impact of country of origin, which can account for significant intra- and inter- group variation in prevalence of disorders. Mexican Americans and Cuban Americans had rather similar lifetime, six month or one month prevalence rates of major depressive illnesses, which were at the lower end of the five-site range for the ECA. By contrast, Puerto Ricans had much higher rates; their six month prevalence rate was more than twice as great as that of the other two Hispanic groups.

Alcohol abuse/alcoholism causes family problems and is manifested in a high percentage of alcohol related deaths among Mexican Americans. Mexican Americans abused alcohol 5.5 times more frequently than other drugs, whereas non-Hispanic White men were less than one-half times as likely to abuse either. Rates of drug abuse/dependency for non-Hispanic Whites was 1.5 to 7 times as high as for Mexican Americans, depending upon sex and age group. Immigrant Mexican Americans were less likely than non-Hispanic Whites to have a diagnosis of drug abuse/dependency compared to non-Hispanic Whites.

Less acculturated Mexican Americans under-utilize mental health services to a greater extent than the more acculturated. Hispanics have much lower admission rates for inpatient psychiatric services. Hispanics rate of admissions to state and county mental hospitals in most age categories are not markedly different than those for non-Hispanic Whites. Mexican Americans were significantly less likely to use specialized mental health care compared to non-Hispanic Whites. Mexican Americans were significantly less likely to have visited a mental health specialist compared to non-Hispanic Whites and only half as likely to have visited a general health care practitioner for mental health reasons.

Native Americans

Alcoholism and suicide among youths remain significant mental health problems among Native Americans. Native Americans experience extremely high rates of alcohol abuse and dependency and their associated problems. It has been estimated that "alcohol abuse and its consequences are nearly twice as pervasive among Native Americans as among any other population in the U.S." Between 1978 and 1980, nearly 25% of deaths of female Native Americans could be attributed to alcoholic cirrhosis, a rate 37 times higher than that of their White counterparts.

Suicide was the ninth leading cause of death for Native Americans of all ages during the period 1984-86. Native American females 5 to 14 years old are nearly three times as likely to have committed suicide as other American girls in that age group. Neurotic disorders are more prevalent and psychoses/schizophrenia much less prevalent among Native Americans than either Whites or minorities as a whole.

Of the more than 280 diverse American Indian populations, some are characterized by binge drinking followed by periods of sobriety, while other groups remain almost totally abstinent. American Indians' rates of alcohol abuse and alcoholism are several times higher than the general population's and liver cirrhosis is the fourth leading cause of death.

It is my opinion that the delivery of mental health services, the manner in which services are delivered, the frequency of accessing services available, the perception of mental illnesses and associated disabilities are influenced by, and in many cases directly related to, education, income, cultural conditioning, reliance on authority, resistance to change moral judgement and stereotyping. Stereotyping occurs when there is a consistent repetitive unalterable and unbalanced presentation of social, cultural and social behavior based upon and defined by an individual or individuals of another culture, race or social background. As our knowledge of the many variables which affect the prevalence of mental health (e.g., housing, income, food) increases, strategies for prevention and effective treatment systems will improve.

In today's multi-cultural society, mental health workers must consider factors such as beliefs, attitudes, language communication difficulties and observations of patients. The mental health workers must be able to correctly interpret symptoms and be able to correctly interpret the psychiatric symptoms within the cultural standards of the patient/client.

In order to meet the current mental health needs of society, service providers will need innovative programs which include the traditional interventions such as the psychotherapies and medication management, but must also focus on the establishment of programs for the development of communities. Efforts must also be made to stimulate the communities efforts and their own initiative. There must be an increase in the training of volunteers as change agents in the community. These activities can be carried out with a positive attitude by considering the needs of the community, the communities current realities within the social history and culture. There must be created within the community creative alternatives for problem-solving without imposing it in an authoratative manner to promote mental health.

It is obvious to me that African Americans must go through a process of self-liberation and rebirth. There must be an undoing of the effects of slavery and restructuring of relationships with one another and with descendants of slave owners on the basis of our new situation. Consciousness must be raised and translated into effective positive action. Then and only then can prevention efforts be relevant and current services be efficiently utilized. For African Americans and other minorities there must be a reconstitution of integrity and a restoration of rights to the past as well as the future.

Racism

The single largest mental health problem of the U.S. is "racism". Yet, the commitment to address this illness is small. Fear is the major obstacle. Fear, stereotyping and labeling have resulted in White insensitivity, indifference, thus helping to create massive pockets of poverty and despair in the U.S. Conformist racism among other non-Black minorities as well as religious and cultural minorities are adding to the conflicts which divide the U.S. resulting in more exploitation, alienation, discrimination and maintenance of pockets of poverty. We must always remember that racism has an adverse affect on the productivity of the oppressed as well as the oppressor.

Decision Makers

Decisions regarding allocation of funds for mental health services, and community development are influenced in part by geo-political consideration rather than domestic issues of quality of life.

Geo-political decisions are frequently made without consideration for the mental health impact of citizens affected. These decisions do in fact reflect the priorities of government and suggest the overall focus of society. Decisions to support financially foreign governments and military build-up while inadequately ignoring domestic ills, reflect a lack of awareness that Americans are suffering and a lack of understanding of what is needed for the good of all Americans during these very dynamic and complex times. To meet these new challenges, we must seize the opportunities to create new levels of positivism within our individual citizens and communities.

We must constantly challenge our own denial and amnesia regarding the presence of racism and discrimination. We must constantly ask ourselves, how are we influenced as health care givers, administrators, social scientists, business persons and leaders, etc.?, What are our fears and biasnesses and to what extent do we discriminate at both the mirco and micro-levels consciously and unconsciously? What are our attitudes regarding race and cultural differences?

We must see ethnocentrism as a positive, healthy and rational process to be understood with respect and tolerance. It is imperative that we understand and stop the frequent cycle of infants and children of teenage parents experiencing physical, social and psychological neglect, physical and sexual abuse, inadequate housing, poor clothing and hunger. The cycle includes abandonment of children to the welfare system and foster homes. These children experience failure academically and later fail on achievement examinations. Often they fail to attend school and eventually drop out. Many become involved in drugs to medicate their un-diagnosed depression or sell drugs to eradicate their family's financial problems. Many Black

children become obsessed with sexual acting out to compensate for an intense sense of unmet dependency needs that their teenage parents did not meet. They are at high risk to contract AIDS, venereal diseases, and disabilities.

Significant attitudinal changes and priorities must be altered so that we can find new ways to benefit from old technologies. The distortion, stereotyping and sensationalizing of minorities, particularly African Americans in newspapers, television, radio, and movies, present African American children specifically with tremendous obstacles to the development of health images. Television, for the exclusive use of entertainment, is a luxury we cannot afford. We must develop a new level of integrity in business and government so that we, the American people, can know the truth about the current state of affairs in the U.S. Then, we can decide what roles each of us can take to contribute to the identification of the problems and implementation of solutions.

Let us not forget that many Americans are suffering today. Too many American families are dysfunctional, and their children are addicted to alcohol and drugs. Many Americans have lost their jobs, and are dependent on government assistance. Many Americans are homeless and confused, angry, and disenchanted. Many of these Americans are White. We must move all the people forward through unity of purpose under one flag. We must not fear the desire of non-Whites to seek their past for knowledge of their history which can enable them to decide their future. Pride and happiness can evolve as a consequence.

What is needed is nationalist pride which acknowledges the unique histories of all ethnic and racial groups. Each citizen of this country must go through a "consciousness of the self". This will facilitate communication among groups. We must attempt to undo the distortion, disfigurements and distortions of the African American history and histories of other minority groups. We must appreciate the heterogeneity of African Americans.

We must reject the notion that there is something inherent about minorities which puts them in inferior situations compared to Whites and results in their exclusion thus engendering, resentment and bitterness. This attitude has significant clinical impact on treatment outcome. The government has been consciously or unconsciously, indifferent to Blacks. This indifference and non-communication plants the seeds for mutual destruction. African Americans must undergo a process of self-liberation and rebirth in order to overcome the effects of slavery. They must also re-structure their relationship with one another and with other minorities and Whites. These new relationships will be the basis of new relationships and can create new situations for change.

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Reaction to Mental Health and Minorities: Emerging Issues

Henry Williams, Director
Intensive Case Management
Bronx Psychiatric Center
Bronx, NY

Thank you for inviting me to join in this significant review of contemporary needs in disability for people of color and the necessary strategy and planning for the future.

We meet today to discuss the needs of people of color who suffer disabilities associated with mental problems. We also meet against a background of massive trauma, violence and destruction, spawned by the Simi Valley jury's decision in the Rodney King case - a decision rendered just seven days ago, a verdict whose immediate and long term results will be studied and analyzed for years to come. And I might add, for me at least, the verdict suggests the need for psychiatric treatment and services not only for the police who senselessly beat Rodney King, but for the jurors who apparently had difficulty connecting what they saw with its legal implications and outcome - or who apparently only recently arrived from an unknown planet.

Dr. Summers in his presentation identified a number of issues and demographics which impact upon African American, Hispanic, Asian, and Native American populations in the United States. He noted not only the increased violence affecting the nation, but the changing patterns and number in drug and alcohol usage, and some of the social and family ills which call for continued, increased attention. While drawing many of his observations from the data contained in the U.S. Census Report and writing of the 80's, his observations, however, are still very prevalent in the 1990's.

In the brief time allotted, let me touch on some of his observations I see as having both short and long term implications for people of color. I would also like to offer some thoughts on what we need to consider as strategies for change.

I come from New York, a city and state which often prides itself in being a leader. The issues raised by Dr. Summers are not unique only to our city and state but are emerging as mental health concerns nationally, in both urban and rural settings. In the program I direct in New York, we are seeing growing numbers of non-white clients categorized as Mentally Ill Chemical Abusers (MICA) where the

primary disability is felt to be mental illness. Their frequent and uncontrolled use of crack, alcohol and other drugs makes programming and rehabilitation efforts difficult and unpredictable. Increasingly, issues of program termination are made against backgrounds of chemical abuse, a circumstance that drives the decision and makes efforts at treating the primary mental disability often one of secondary status. Program and staff ability to cope with the disruptive and hostile manifestations of clients either actively using drugs and alcohol, or having reactions to withdrawal, can tend to be the primary determining factor in keeping or dropping clients. The severe shortage of staff trained and qualified to deal with this population only further exacerbates the problem and places additional burdens on the resources available and limits the numbers who can enter and successfully complete treatment.

Growing numbers of crack users are also switching to heroin both in tandem with crack or as the drug of choice, with serious implications for treatment. Another major trend in both the African American and Latino communities is the rise in HIV infected babies and AIDS. Taken together, these changes add other dimensions to be considered in devising treatment services and/or programs for women of color suffering mental disabilities and families who must face the reality of AIDS and/or caring for a child found to be HIV positive. Recently, the New York Times estimated that the percentage of Black women, 20-29 years old, giving birth to HIV infected babies has increased considerably between 1988 and 1991 while dropping slightly for Hispanic women and by over 50% for White women - a telling piece of data for the future when viewed in the context of prevention and education.

Recently in New York, we learned that the number of non-white children and adolescents entering the foster care system was rapidly approaching, with the danger of surpassing, the number of non-whites being incarcerated each year. With increasing frequency, we hear of the sexual and physical abuse of such young persons in foster care whose long term mental health is seriously threatened. Many graduate into adulthood with serious, difficult to treat mental disabilities of a sociopathic, borderline nature, often requiring long term, highly specialized treatment and possible institutionalization. Increasing numbers also show up in the statistic of active non-white substance users.

Of growing concern is the ravages of homelessness with its explosive, geometric growth. While not all homeless persons and families are people of color, a large percentage are African American and Hispanic. The attendant stresses associated with survival tend to also increase the deviant pathology of those already, and more recently known to the mental health system while impacting previously stable persons and families less likely to seek or enter treatment. Everyday, we are witnessing increasing numbers of homeless children and adolescents living on the city's streets alone and with little or no chance for a positive, stable, and productive future. Thus, we see the next generation of non-white persons with mental disability developing within our midst and before our eyes.

Any analysis of the mental health system and its relationship to non-white people cannot be complete without mentioning the growing numbers of incarcerated

African Americans, Hispanics, and Asian Americans. Trapped in a system whose emphasis is upon management and punishment, with little attention to rehabilitation, many return from prison as hostile, aggressive and assaultive members of the community, burdened with unidentified or actively manifesting symptoms of acute psychiatric disorder. For many people of color, prison and mental institutions become revolving doors of entry and exit with little or no meaningful contribution or rehabilitation being observed. In the program I direct in New York, it is not infrequent to have clients diagnosed as psychiatrically disabled, drug or alcohol addicted, suffering from HIV or AIDS, formerly in foster care, living in homeless shelters or on the streets of the city, and previously incarcerated and/or awaiting trial for new difficulties. In conclusion, one logically asks how do we deal with those growing problems facing the non-white community and those suffering mental illness. Let me note some areas or needs the National Council on Disability should consider:

1. In a speech I recently gave on multi-cultural changes in the United States, I noted that by the year 2050, more than 58% of our society would be people of color. Implications for non-whites with mental disability is thus very apparent. Understanding their cultural variations and mores must be a consideration in any and all rehabilitation and treatment programs, no less true today. At Bronx Psychiatric Center, reacting to this need, we instituted an all Hispanic ward both in terms of staff and patients. The length of hospital stay shortened, incidents were reduced, and the general environment is more relaxed, friendly and culturally relevant. This needs to be considered as a strategy in other settings, where clusters of similar cultural and racial clients or patients exist.

2. Trained staff drawn from non-white communities who understand and identify with the mores and belief systems of people of color must be added to the system. The government needs to make a continuing effort to identify such persons, provide programmatic and fiscal support to enable their training in the mental health disciplines critical to treatment and rehabilitation, and assist in locating employment opportunities in communities of need.

3. We need to recognize and substantially change the social ills impacting non-white communities leading to increased disfunctionality, homelessness, housing shortages, poor education, and others. The Council should consider identifying these as they impact the non-white disability community and advocate for legislative and social change to eradicate or minimize such societal ills.

4. Funding streams need to be adjusted to consider more horizontal cross systems problems and difficulties to focus upon the implications of mental disability across extended families and beyond the nuclear and individual family unit or person. We must preserve the family structure

integration of services and resources that cause breakups due to vertical program and funding systems.

5. A major step forward would be the elimination of disability categorizations which needlessly place labels on children and adolescents that stay with non-white persons into adulthood and often until death. Understanding cultural variations that are not manifestations of disfunctionality but different non-Eurocentric behaviors is critical to this objective. Training people of color and others for work in disability venues serving peeople of color, should aid in reducing this long term and racist practice. Monitoring their professional comment and output is also necessary and essential to practice modification.

In conclusion, let me cite a comment made by Dr. Paul LeClerc, President of Hunter College. In 1989 he taught an elementary French class in which half the students were non-white, but all the photographs and illustrations in the course textbooks were of whites. The next year he used a textbook that pictured French speakers who were Asians and Blacks and the students performed better. "It made all the difference to use that book with that piece of sensitivity built into it," he said, "the text recognized them."

People of color with mental disabilities would benefit tremendously if that kind of sensitivity was more often obtained. Thank you.

Reaction to Mental Health and Minorities: Emerging Issues

Lynda J. Katz, Ph.D.
Western Psychiatric Institute and Clinic
University of Pittsburgh
Pittsburgh, PA

I would like to respond to Dr. Summer's paper in terms of the major issues which I believe he has raised and which are also documented in the literature dealing with mental health and ethnic and racial minorities. These are:

1. The diversity of cultures in terms of ethnic and racial origins;
2. The process of acculturation into the mainstream of American society, as in the past, reflects a white majority culture;
3. Socio-economic factors which have an impact upon the quality of life;
4. The concept of mental illness as an illness among cultural minorities groups;
5. Help seeking behaviors; and
6. Implications for cross-cultural mental health service delivery

1. Diversity

In our attempt to understand phenomena of any sort, whether they be physical events, behavior, peoples, social or political constructs, disease states, theoretical ideas, etc., it is integral to the human cognitive process to categorize as a way as reducing information to manageable proportions. We have done this in the area of mental health and psychiatric illness and we have done this in relation to differing peoples by virtue of their race or ethnic origin. And while there are definite merits to the process of categorization, there are liabilities which we are still in the process of appreciating. For example, we can no longer speak of schizophrenia as if it were a singular entity. Because of its manifestations, since we have identified no isolated caustive agent to eradicate, we have come to appreciate that schizophrenia is most probably the schizophrenias with hypodopaminergic or hyperdopaminergic

dysfunctioning in the brains of those so effected or a combination of both. But we are still, in terms of understanding the etiology and course of the various disease states and treatments, at the tip of the iceberg.

I think a parallel can be drawn with respect to the categorization of ethnic minorities as far as mental health issues are concerned. We are still categorizing African-Americans, Hispanics, Asian Americans and American Indians as though they were homogenous groups of people. And while there is beginning to be a sensitivity to the diversity which exists among each of these ethnic or racial groups, I am not sure that sensitivity is reflected in our treatment programs or in our educational programs for mental health professionals. For example, while we can now read about differences between Mexican Americans, Puerto-Ricans, and Cubanos in terms of values, cultural norms and mores in practice, we do not understand the primary language of this growing minority and its diverse members. In mental health this translates to problems in misdiagnosis, misdirected treatment, and noncompliance with medication for those who actually access mental health services, while the great majority are not even recipients of services regardless of need.

2. Acculturation

In terms of acculturation, researchers have identified stages in the process with which individuals may operate and families may function. It is the responsibility of the mental health practitioner to incorporate an understanding of the acculturation process, initially, into the assessment process and thereafter, throughout treatment and rehabilitation service delivery. Acculturation is a relevant issue whether we are concerned with African-Americans, Central American immigrants, or mainland Puerto Ricans. Whether one uses the terms bicultural or monocultural, culturally immersed or traditionally immersed, etc., where an individual or family is on the continuum of acculturation has specific implications for emotional and cognitive adjustment, both personal and social. For the culturally immersed African American who has adopted the Muslim religion, values and cultural traditions are held which are highly divergent from the acculturated African American who has essentially rejected Black culture, or from the young Black male living in a ghetto with few or no role models and ambiguous community values regarding the use of drugs. In a similar manner, education programs aimed at prevention of AIDS among Puerto Rican women which recognize the traditional role of the woman in this culture will have to adopt a different educational strategy if they are to succeed because many women, particularly the uneducated, at the present time will not and cannot ask their mates to use a condom.

3. Socio-Economic Factors

One cannot look at the unique mental health needs of ethnic and racial minorities without acknowledging the powerful and negative influence of poverty and the caste system it creates. Dr. Summer has given us considerable data regarding the differentials in employment rates, educational attainment, and vocational

opportunities among these diverse minorities. The statistics are staggering at best: 40% of Hispanic origin youth will never finish high school; 54% of the classes for EMR children are comprised of African American youngsters; 39 out of 100 Hispanic children live in poverty. These figures are more startling when one considers that by the year 2010 there will be 47 million Hispanics in this country, outnumbering all minority groups. That's only 18 years from now; 18 years to correct several decades of neglect, lost opportunities, and disenfranchisement at best, ignorance, ill-health, disease, drug abuse, infant mortality, child abuse, imprisonment at worst.

4. and 5. The Concept of Mental Illness and Help Seeking Behavior

The concept of mental illness and help seeking behaviors among culturally diverse populations vary as well. There are excellent educational materials in the literature dealing with an understanding of these issues with respect to specific groups of Asian Americans, Hispanics, African Americans and with American Indians to some extent. At this point, one should be cognizant of the role of the family, for example, in working with Hispanics or with Asian Americans. In like manner, at the risk of stereotyping, privacy regarding the family as a subject of inquiry should be respected when working with persons of African American heritage. Recognition of the wholistic concept of health among Hispanics who do not separate mental health from physical health; family interventions of care for a family member with a mental disorder among Chinese Americans for periods of time far surpassing that of any other ethnic groups for a family member with a mental disorder before outside help would ever be considered; the stigma of mental health treatment among African Americans; the practices of healing and spirituality among American Indians--all of these factors and others have a direct impact upon help-seeking behavior among persons from culturally diverse and minority status backgrounds. Having said this, I recognize that the predominantly white middle class mental health world must go out of its way, albeit necessary, to acquire not only sensitivity but a specific knowledge base if it is to address with any credibility and efficacy the mental health needs of its culturally diverse constituency. It is imperative that professional training programs actively address cross-cultural concerns with respect to the treatment and rehabilitation of mental illness. And, professional training programs must be responsive to the need to educate professionals from culturally diverse backgrounds. An openness to alternative treatment approaches in mental health care which respects culturally diverse beliefs is not only required terms of consumer needs, but would be beneficial to the education of traditional white middle class practitioners as well.

6. Implications for Mental Health

While I left it for last, I think that my remarks thus far have dealt indirectly with the implications for mental health professionals and the related helping professions, their administrators and policy makers. Mental health needs cannot be separated from problems in living needs. We have learned that medication management alone cannot resolve the overwhelming problems in living encountered by those with chronic mental illness. We have put in place a system of intensive case

management as a means of addressing the comprehensive nature of services necessary to assure community adjustment with regard for quality of life issues as well. With individuals (1) who may be or are disabled by virtue of a mental illness; (2) who, in addition, face discrimination by virtue of their minority group status; and (3) as a result live without access to appropriate education, health care, and necessary employment opportunities, mental health practitioners who do not address problems-in-living issues, in addition to being sensitive to and knowledgeable about cultural diversity, and language proficient when necessary, will never be relevant to the needs of minority persons. The unique mental health needs of persons from culturally diverse backgrounds are real. It is not a small problem; it will not go away. It is deserving of our best technologies, know-how, human concern, and long-term commitment.

Reaction to Mental Health and Minorities: Emerging Issues

Doreen M. Miller
Department of Psychology & Rehabilitation Counseling Services
Southern University
Baton Rouge, LA

Dr. Summers stated that there is a direct relationship between general health status and advantaged or disadvantaged status. Also, poor health is a corollary of disadvantaged status. In view of these ideas, this paper will focus on African American women who have long constituted the "Permanent Underclass" of the American social strata. Women and children constitute the fastest growing group of poor people in America.

African American women are faced by an inordinate amount of poverty, yet not enough attention has been focused on their chronic and unrelenting needs. According to Wilson and Neckerman (1986), who cited the work of Bane and Ellwood, poverty among Black children is protracted and could last up to 20 years. Further, the National Advisory Council on Economic Opportunity (1980) indicated that poverty experienced by Black women is 10 times that of White men who are heads of the households. The average income in 1987 for an African American woman head of the household was $10,001 while it was $17,278 for her White counterpart (Statistical Record of Black America, 1990).

Further, 70% of female-headed families living below the poverty level are headed by African American women (Scott, 1991). African American women are often localized in low paying jobs and their earnings constitute a considerable portion of the family income. Katz (1989) suggested that the feminization of poverty has helped to garner support for the severe and overwhelming poverty of women in general but has served to obscure the harsh circumstances of African American women. The economic emotional condition of African American women is also affected by changing family trends among African Americans. Among the issues are:

- Black couples are separating at a rate of five times greater than whites.
- Black males die from accidents and violence at 1.5 times the rate of White males.

- Black men die from homicide at six times the rate of White men.
- More than two million Black men were arrested in 1981, accounting for one-third of all arrests in the nation.
- Black men have a life expectancy of 65.5 years, compared with 70.5 years for White men.

The changing family trends have a tremendous impact on the well-being of the African American women. As African American men become incarcerated or die, African American women are forced to care for their children alone. The repercussions of being a single parent can result in depression, helplessness, hopelessness and loneliness. The lack of economic and emotional support from a male companion/spouse diminishes the emotional quality of life for many women.

The literature suggests that women, because of their socialization are particularly prone to depression (Belle 1990; Guttentag, Salasin & Belle, 1980). Given the circumstances, the potential for depressive symptoms among African American women is maximized.

Poverty, changing family trends, normative and non-normative stressors, daily hassles, and multiple roles have taken their toll on the African American woman. She is crumbling under the myth of "The Strong Black Woman". The impact of the vicissitude of life on both psychological and physical health of the African American women have reached a crisis. As noted by Scott (1991), poverty increases their succeptability to mental illness. African American women have the highest admission to out-patient psychiatric services and of the 680,726 women admitted to a varity of inpatient facilities, 20% are African American women. Given that African Americans constitute 12.5% of the general population, it appears that a disproportionate number of African American women are experiencing mental disorders.

The deleterious effects of poverty and stress have resulted in a number of chronic stress related illnesses among African American women. There are some startling facts which depict the status of African American women's health as follows:

Life Expectancy:

- Only 6.4 % of Black females live past the age of 64 compared to 10% of White females.
- The incidence of high blood pressure is three times higher among Black women.
- Death rates from hypertensive cardiovascular disease are twice as high for Black women. Chronic hypertension accounts for up to 30% of maternal deaths.

- Systemic lupus erythematosus is said to be three times more common in Black women.
- Black maternal mortality rates are three times higher, and the infant mortality rate is nearly twice as high.
- Death rates from diabetes are 35% higher among Black women.
- Four times as many Black women die from homicide.
- Data are not available on the medical and emotional repercussions of homicide attempts and abuse.
- Teenage birth rates for Blacks remain higher than for Whites.

Substance abuse: Alcohol and tobacco have long taken their toll on African American women's health. In the last half decade, however, these "Traditional" problems of legalized drug dependency have been diminished by the crisis caused by the epidemic of the dependency upon crack cocaine. Crack cocaine has impinged upon women's and infants' health as has no other drug in U.S. history. A recent Florida study found that Black women were 10 times more likely than White women to be referred for prosecution for substance abuse while pregnant, even though the same percentage of women of each race were actually using harmful drugs. Black women are six times more likely to develop cirrhosis from alcoholism than are White women (Scott, 1991).

There is an obvious disparity between the health of Black women and White women. However, the recent interest in women's health seems to focus more on the health needs of women in general. The Center for Women's Health research has listed as priority areas: osteoporosis, breast cancer, colon cancer and heart disease (National Institute of Health, Office of Disease Prevention, 1992). Although the needs of all women are important, diseases with high incidence among African American women such as diabetes, cervical cancer, fibroid tumors (46% of African American women) AIDS and, lupus have not been considered among priority areas of concern (Scott, 1991).

Empowerment, self-reliance and self-efficacy are all words used in discussions about African American women on welfare. In order to empower the African American woman, she must be able to access and purchase the commodity of health. Good health is empowerment and empowerment is self-reliance and self-efficacy.

The following suggestions are important components of African American women's empowerment and quest for good health.

1. African American women must be included in problem identification and definition. A national task force consisting of African American women from all sectors of the community is needed to serve as

an advocate in understanding the unique psychophysical needs.

2. Resources must not only be available, they must be accessible to ensure maximum utilization (e.g., transportation to resource centers when necessary).

3. Efforts to encourage use of resources are paramount.

4. The relationship between African American women and the ecological systems upon psychophysical health and quality of life needs to be examined (mesosystem, ecosystem and macrosystem).

In summary, poverty, the stress of living, and the position of the African American woman in the American society places her in double jeopardy. She carries two stigmas "Woman and Black" and these do not ease her load in anyway. They seek to further compound her problem. The psychic wound of slavery has stigmatized the Black woman as aggressive, promiscuous, loud, bossy and demanding. These characteristics attributed to the African American woman intensified placed her on emotional demand. (King, 1992).

Contrary to common belief, gender places her automatically at the bottom of the social hierarchy. In our society, when we speak of the population in general, we speak of White men. When we speak of African Americans, we speak of African American men. When we speak of women, we speak of White women, (King, 1992). The African American woman is lost in the collective assessment and she suffers for it.

Daily stress coupled with illness is not new to the African American woman and the appearance of condition do not suggest amelioration soon. Steps are necessary to aid her in better management of life. There are groups within the African American community such as the National Black Woman's Health Project (NBWHP), founded by Billy Avery, which are attempting to help women in the management of their health (psychological & physical). One of the core components of the NBWHP is support. It is imperative for African American women to break the shackles of the myth of the "Strong Black Woman". No longer must we continue to grin and bear it. Behind the facade of strength is great pain. African American women have strengths which must not be forgotten, but it is also important to recognize that they hurt and their pain is a symptom of their condition. Sharing the pain aides in easing the burden. Zora Neal Hurston, in her book, Their Eyes Were Watching God said: "The Black woman is the mule of the race and she has lived it out in many ways and to her determent." Through empowerment, African American women will be able to enhance their quality of life as they contribute to the American Society.

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VOCATIONAL REHABILITATION

81 92

The Vocational Rehabilitation of Minorities

Frank L. Giles, Ph.D., CRC
Department of Special Education
& Rehabilitative Services
Jackson State University

It is estimated that over 43 million Americans have some type of disability. Of this total in 1988, some 13,420,000 working-age adults between the ages 16-64 had a disability and 7,457,000 or 55.6% of these persons were considered to be severely disabled (Bowe, 1992). As of 1988, Blacks and Hispanics represented one in three of working-age adults with a severe disability, compared to just over one in five in 1982. While the proportion of Whites with work disabilities fell from 8.4% in 1982 to 7.9% in 1988, during the same period the proportion of disabilities among Blacks rose from 13.4% to 13.7% and for Hispanics 8.0% to 8.2%, respectively (Bowe, 1990, 1992). According to the Bureau of the Census (U.S. Department of Commerce, 1989), approximately 3,523,000 Blacks and Hispanic Americans have a working-age disability (this figure excludes individuals in institutions). If one combines this total with individuals who are Asian-American and Pacific Islanders, along with Native-Americans with disabilities, a sizable portion of people of color in the United States have disabilities.

This paper will focus on problems encountered by minorities in accessing the state/federal vocational rehabilitation system, how minorities have fared in the system, the lack of trained minorities in the profession of vocational rehabilitation (VR) counseling, and a brief comparison of private-for-profit VR and state/federal VR programs. General recommendations for each of the above topical areas will also be provided.

For the purpose of this paper, Black and African-American will be used as an interchangeable terms. The term Hispanic-American will be utilized to describe Americans of Mexican origin, Puerto Ricans, and Central and South Americans. The author will utilize ethnic terms recommended by the primary sources when referring to certain Hispanic ethnic groups in an effort to accurately depict the needs of this diverse population. Similar attempts will also be made when describing both Americans of Asian descent and Native-Americans.

Public Vocational Rehabilitation and Minorities

African-Americans with Disabilities

The heritage of Americans of African origin continues to evolve with regard to their ethnic identity within American society. As depicted in the late Alex Haley's book Roots, African-Americans were the only racial group forcibly brought to America's shores, enslaved, sold as property, and counted as three-fifths of a person (Giles & Lustig, 1988). A significant portion of African-Americans still carry psychological scars caused by years of bigotry which in turn has led to an air of mistrust in the White majority. In a recent poll of readers of Ebony (1988), 66% of the respondents felt that Whites have "little" sympathy for the struggle of Blacks. Another 25% indicated that they felt that Whites have "no" sympathy at all. These findings suggested that it is likely that African-Americans may be somewhat skeptical or in some cases passively resistent to efforts to initiate services such as VR.

In a landmark study Atkins and Wright (1980) using data provided by the U.S. Department of Education, Rehabilitation Service Administration (RSA), they found that Blacks were more likely to be found ineligible for VR when compared to Whites. If found eligible, Blacks were less likely than Whites to be rehabilitated. They also found that Blacks, when compared to Whites at referral for VR, were more likely to be poor and on welfare. The educational level of Black applicants for VR was on a lower plane than for Whites. Blacks were less likely to be provided education or training. Less costly VR services were provided for Blacks.

Danek and Lawrence (1982), in a review of rehabilitation outcomes, found that more time was required for Blacks to be accepted for VR services when compared to Whites. In a recent analysis of data from the Pennsylvania Office of Vocational Rehabilitation conducted by Herbert and Martinez (in press), one in three (33%) Anglos (Whites) were found to be ineligible for VR services when compared to two in five (40%) persons of color. "By definition, ineligibility for services results when the counselor perceives that either the client's disability does not represent a substantial barrier to employment or that there is no reasonable expectation that with rehabilitation services, the client will achieve employment" (Herbert & Martinez, in press, p. 8).

RSA data indicated that Blacks represented 18.2% (see Table 1) of all rehabilitated cases in fiscal year (FY) 1984 (U.S. Department of Education, RSA 1989).

Table 1
Characteristics of Persons Rehabilitated by State Vocational Rehabilitation Agencies Fiscal Years 1986 and 1984

	1986		1984	
Items	Total	Percent	Total	Percent
New Applications (a)	594,000	---	594,000	---
Percent accepted (b)		58.0		59.0
All rehabilitations	223,354	---	225,772	---
Mean Age	32.6 years		32.5 years	
Sex Reporting (c)	214,058	100.0	218,915	100.0
Male	119,013	55.4	123,821	56.6
Female	95,045	44.6	95,094	43.4
Race Reporting (c)	213,854	100.0	218,245	100.0
White	170,768	79.9	174,379	79.9
Black	39,088	18.3	39,813	18.2
American Indian/ Alaskan Native	1,109	0.5	1,240	0.6
Asian and Pacific Islander	2,889	1.4	2,813	1.3
Reporting Yes or no Hispanic origin (c)	218,554	100.0	209,420	100.0
Persons of Hispanic Origin	15,659	7.2	13,464	6.4
Persons not of Hispanic Origin	202,895	92.8	195,956	93.6

a=Applicants processed for program eligibility
b=Percentage of applicants accepted for services
c=Number of individuals reporting requested information

For FY 1986, Blacks represented 18.3% of all rehabilitated cases, however in FY 1988 and FY 1989 (see Table 2) the numbers declined to 17.7% and 17.4, respectively (U.S. Department of Education, RSA, 1990). By comparison,

Table 2
Characteristics of Persons Rehabilitated by State Vocational Rehabilitation Agencies Fiscal Years 1989 and 1988

	1989		1988	
Items	Total	Percent	Total	Percent
New Applications (a)	624,000	—	606,000	—
Percent accepted (b)		58.0		58.0
All rehabilitations	220,408	—	218,241	—
Mean Age	33.8 years		33.3 years	
Sex Reporting (c)	219,953	100.0	218,357	100.0
Male	123,017	55.9	122,517	56.1
Female	96,936	44.1	95,840	43.9
Race Reporting (c)	219,518	100.0	217,785	100.0
White	177,244	80.7	175,150	80.4
Black	38,156	17.4	38,573	17.7
American Indian/ Alaskan Native	1,286	0.6	1,210	0.6
Asian and Pacific Islander	2,832	1.3	2,852	1.3
Reporting yes or no Hispanic origin (c)	214,240	100.0	217,945	100.0
Persons of Hispanic Origin	17,454	8.1	16,381	7.5
Persons not of Hispanic Origin	196,786	91.9	201,524	92.5

a=Applicants processed for program eligibility

b=Percentage of applicants accepted for services
c=Number of individuals reporting requested information

Whites in FY 1984 represented 79.9% of all cases rehabilitated representing an increase to 80.7% in FY 1989 over the same period. It should be noted that the proportion of Blacks with a working-age disability was 13.0% in 1984 followed by an increase to 13.7% in 1988. For the same period between 1984 to 1988, the number of Whites by proportion with a work disability fell from 8.1% to 7.9%, respectively.

Atkins (1988) advocated utilizing an asset-oriented strategy in providing VR services for African-Americans. She observed that rehabilitation philosophy is built upon a principle which predicates that an individual's strengths and abilities should be developed to facilitate growth. From her viewpoint, the strategy should reflect "a belief that positive outcomes originate from shaping strengths and failure results from a concentration on limitations, fears and negatives" (Atkins, 1988, p. 45).

In a unique study of rehabilitation outcomes and environmental support for Blacks with disabilities, Belgrave and Walker (1991) found that individuals who owned vehicles were twice as likely to be employed than those with no transportation. The researchers perceived employment as leading to being able to purchase a vehicle as opposed to vehicle ownership leading to employment as important. Social support was found to be the next strongest predictor of employment of Blacks with disabilities.

Hispanic-Americans with Disabilities

"Hispanic" is often used as a descriptor of people of Mexican descent, Puerto Ricans, Cubans and persons from Central and South America. Arredondo (1991) noted that people from Central and South America, often prefer to be identified with their national origin, such as Dominican or Columbian. Fierro and Leal (1988) suggest that Americans of Mexican origin prefer to be described or addressed as "Chicano". Arredondo (1991) and Fierro and Leal (1988) noted that "Latino" may be a more responsive term and is sometimes preferred to "Hispanic".

Socialization and acculturation by Latinos is often impeded by bilingual ability, color, migration and/or immigration, legal or illegal status, and membership in a specific subgroup (Arredondo, 1991). RSA currently employs a client classification system which accounts for perceived differences in racial and ethnic identity among Hispanics (U.S. Department of Education, RSA, 1990). By definition, racial identity denotes a human biological characteristic, whereas ethnic identity relates to an individual's perceived cultural heritage. At face value, such classification strategies are usually benign and provide a means to accurately document Hispanic consumers of VR services. However, the danger of such systems is the same information can be employed to "screen-in" or "screen-out" certain consumers.

There is very little empirical research about the participation of Hispanics in

the state/federal VR system. Rivera (1974) found that Hispanics, when compared to Whites, were more likely to be found ineligible for VR services. He also reported that Hispanics, when compared to Whites, remained in referral and applicant statuses for a longer duration, were less likely rehabilitated, supplied less academic training and received less money for VR services. Herbert and Martinez (in press) also found that Hispanics were more likely to be found ineligible for VR services and less likely to be successfully rehabilitated when compared to Whites.

RSA data indicates that individuals of Hispanic origin in fiscal year (FY) 1984 (see Table 1) represented 6.4% of all cases rehabilitated. By FY 1989 (see Table 2), the number of Hispanics rehabilitated increased to 8.1% of all cases rehabilitated.

Rivera and Cespedes (1983) advocated reaching out to Hispanic persons with disabilities by visiting them in their cultural and personal environment. They further recommended visiting Hispanic churches, community organizations, and meeting with community leaders as a means to increase Hispanic persons involvement in VR services.

Asian-Americans with Disabilities

Asian-Americans are far from the homogeneous group they seem to be. Within the category of Asian-American and Pacific-Islanders there exists at least 32 distinct ethnic or cultural groups (Wong cited in Leung & Sakata, 1988).

The shear magnitude of the various ethnic and cultural groupings indeed suggests that rehabilitation professionals should utilize caution when exercising broad generalizations about Asian-Americans with disabilities. Census data from 1980 indicates that there are approximately 3,726,000 Asian and Pacific Islanders in the U.S. Approximately 74% of the population has completed four years of high school or more. The largest ethnic group represented are the Chinese-Americans with an estimated population of 812,000.

Asian-Americans have been subjected to the "model minority" label. This notion fosters a perception that Asian-Americans have somehow "over-come" their minority status and succeeded in all facets of American life. This designation further suggests that Asian-Americans should thus be denied or have limited access to public support available to other minority groups.

RSA data indicated that in FY 1989 (see Table 2) the public VR program rehabilitated 2,832 Asian and Pacific Islanders. Similar numbers of individuals were rehabilitated in fiscal years 1984, 1986 (see Table 1) and 1988.

Whether to seek VR services may depend upon the length of time a person has been present in the U. S. For example, immigrants and refugees may not be familiar with the language or customs of the U.S. Leung and Sakata (1988) noted some immigrants have an advantage over refugees by preparing for relocation and learning skills which may be needed for successful adjustment. On the other hand, refugees

may have no choice but to seek security in a new country secondary to political pressures in their country of origin. Other factors which may create barriers to the VR of Asian-Americans include acquisition of the language of the dominate culture, traditions and customs (e.g., filial piety), perceptions of the sick role, and family support (Leung & Sakata, 1988).

Native-American with Disabilities

There are 309 Native-American tribes and 197 tribal villages in Alaska recognized by the U.S. Government (Federal Register, cited in Martin, Frank, Minkler, & Johnson, 1988). Martin et al. reported that RSA has funded 13 tribal-operated VR projects as of July 1988. In 1975, the Navajo Tribe became the first Native-American Tribe to operate a VR program which was funded through a grant from the Arizona Rehabilitation Services Administration (Guy, 1988). In 1983, it was estimated that nearly 180,000 Navajo people lived on the Navajo reservation which is located in the states of New Mexico, Arizona and Utah (Lowery, 1983). From 1981 to 1988, approximately 400 individuals with disabilities were placed into employment as a result of the Navajo program.

RSA national data indicated that in FY 1984, 1,240 Native-Americans and Native Alaskans were rehabilitated (see Table 1). Overall, rehabilitated cases have continued to be rather stable for fiscal years 1986, 1988 and 1989 (see Table 2).

Several factors have been found to present barriers to the VR of Native-Americans who live on reservations. These factors include: (a) cultural differences, (b) transportation problems to obtain VR services, (c) few employment opportunities on or near reservations, (d) a lack of self-initiative and commitment to VR long-term goals, (e) language problems, and (f) substance abuse problems. Problems associated with Native-Americans living in urban areas were limited family and cultural support, no recognized central agency with whom to communicate social service needs and a greater financial burden associated with living in a city (White cited in Martin, et al., 1988). Similar findings were reported in a study of 332 VR counselors in 25 states and two VR programs operated by tribes. Martin et al., (1988) found that 50% of the clients-on-reservation counselors felt that it was okay for their clients to accept native healing approaches to disabilities. Only 31% of the clients-off-reservation counselors approved of such practices. Both clients-on-reservation counselors and clients-off-reservation counselors overwhelmingly reported the importance of the remediation of deficits in English proficiency among clients. Over 90% of both counselor groups reported that it was important to receive test results which were culturally relevant.

Finally, the study indicated that client-on-reservation counselors reported that "Indian Attitudes Toward Health and Disabling Conditions" ranked first and "Interviewing and Counseling Skills with Indian Clients" ranked second with regard to VR counselor training needs. Clients-off-reservation counselors indicated that "Services Available to Indians Living Off Reservations" ranked first and "Vocational Evaluation Approaches" ranked second with regard to training needs.

Training of Minorities in Rehabilitation Counseling

The National Council on Rehabilitation Education (NCRE) represents rehabilitation educators, trainers, researchers, doctoral students, and others primarily concerned with the preparation and maintenance of professional standards for individuals who deliver services to persons with disabilities. The NCRE 1991-92 Membership Directory (1992b) lists 72 institutional members composed of colleges and universities in the U.S. and Puerto Rico. To determine the number of historically and predominantly Black colleges and universities with programs in rehabilitation education, the author compared the NCRE institutional membership list against a list 117 recognized predominantly and historically Black colleges and universities (HBCU) (National Association for Equal Opportunity in Higher Education, 1992). There were four rehabilitation education programs which are institutional members of NCRE and located within HBCU. These institutions include Jackson State University (Jackson, MS), Southern University (Baton Rouge, LA), South Carolina State University (Orangeburg, SC) and the University of Maryland - Eastern Shore (Princess Anne, MD). The University of Maryland - Eastern Shore program began in 1988 and offers a bachelor's degree in rehabilitation services. The other three programs offer master's level training in rehabilitation counseling. (The author is personally aware of two additional rehabilitation programs located in historically black colleges.) Fort Valley State College (Fort Valley, Georgia) has a master's level rehabilitation counseling program and Talladega College (Talladega, Alabama) has a bachelor's level rehabilitation services program.

By reviewing the program descriptions of all rehabilitation programs listed in the current NCRE Directory (1992b), only two programs identify themselves as having a significant enrollment of Hispanic students. These programs include the University of Puerto Rico which offers a master's degree in rehabilitation counseling and the University of Texas - Pan American (Edinburg, Texas) which offers a bachelor's degree in rehabilitation services. The University of Hawaii (Honolulu, HA) offers a master's degree in rehabilitation counseling and has a significant enrollment of Asian-Americans.

NCRE data pertaining to master's level rehabilitation counseling programs indicates that between 1989 to 1991 non-white students enrolled in master's level rehabilitation counseling programs represented only 15.8% (see Table 3) of all rehabilitation counseling students from reporting institutions (NCRE, 1992a). Roughly, the average number of non-white students enrolled in master's level rehabilitation counseling for the years between 1982 through 1991 (no data was collected in the 1986-87 academic year) was approximately 17.8%.

Table 3
National Council on Rehabilitation Education Master's Level Rehabilitation Counseling Programs Student Enrollment Data

Years	82-84	84-86	87-88	89-91
Surveys Returned	60	56	61	58
Number of Graduates Average per program (two year period)	11.8	13.5	11.8	13.6
Demographics Percentage (%)				
Non-White	16.6	15.6	23.5	15.8
White	83.4	84.4	76.5	84.2
Females	72.8	74.8	78.1	71.8
RSA Trainee	48.4	50.7	58.3	53.3
Individual with Disabilities	15.7	15.2	20.7	21.6

Note: Data for the Fact Sheet for 1986-87 was not collected.

The U. S. Department of Education, RSA provides grant support to several academic programs in higher education to meet the employment needs of state/federal agencies responsible for providing VR services. NCRE data indicated that between 1982 to 1991 (no data was collected in the 1986-87 academic year), RSA stipends were extended to approximately 52.6% of all students enrolled in master's level rehabilitation counseling programs.

According to the National Training Needs Analysis and Summary of 1990, (RSA, 1991) regional reports have recommended continued funding for universities which recruit "students that are bi-lingual, or represent minority populations" (p. 15). Available information regarding RSA grant support to rehabilitation education programs in minority institutions indicates that Jackson State University (1992 last year of three year grant), South Carolina State University (personal communication Eddie Glenn, April 6, 1992) and the University of Texas - Pan American (through 1994) (NCRE, 1992b) are currently funded.

Clearly, the need to continue to provide RSA support through grants to institutions of higher education with significant enrollment of minority students is critical to maintaining and increasing the numbers of minority persons represented in the rehabilitation profession.

Private-for-profit Vocational Rehabilitation

With its beginning in the 1970's in California, private-for-profit rehabilitation

firms have experienced a burgeoning growth in providing VR services to individuals typically with industrially related injuries. Referral sources for private sector firms include insurance companies, attorneys, state workers' compensation bureaus, private industry, employee assistance programs and various other sources. Matkin (1983) observed in a study of members of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) that 94.6% of respondents reported providing services in the area of vocational counseling and 70.1% in job restructuring consultation. He noted that these services did not appear to reflect the traditional role and function of rehabilitation counselors in state/federal VR agencies. Commonly offered services in the private sector such as medical case management, vocational testimony, labor market surveys, and job analysis have generally received less emphasis in the public sector.

By comparison, rehabilitation counselors in the private sector usually carry a caseload between 25 to 30 clients, whereas in the public sector it is common for caseloads to exceed well over 100 clients. Hence, it is difficult to compare the private sector and state/federal rehabilitation delivery systems with regard to the effectiveness of services provided to minorities with disabilities.

Summary

In general, minorities with disabilities are less likely accepted or found eligible for state/federal (VR) services when compared to Whites with disabilities. If accepted for VR services, minorities are less likely rehabilitated and provided fewer opportunities for academic training when compared to Whites. RSA data regarding individuals rehabilitated between FY 1984 to FY 1989 indicated that the number of American Indians/Alaskan Natives, and Asian-Americans and Pacific Islanders rehabilitated cases have remained fairly stable during the period. The number of Hispanic-Americans rehabilitated increased slightly during the same timeframe. Even though the number of African-Americans with a work disability increased between 1984 to 1989, the number of African-Americans rehabilitated by RSA decreased.

Both the American Association of Counseling and Development (AACD) and the American Psychological Association (APA) (both organizations have a division devoted to rehabilitation) have recognized the significance of service delivery systems which appropriately meet the needs of the culturally diverse American population. In 1973, the Vail Conference of APA recommended to providers of psychological services that it is unethical for individuals who are not competent in understanding the needs of persons from culturally diverse populations to supply services to such populations.

Rehabilitation counseling pre-service academic training programs may also have a critical impact upon the success or failure of minorities with disabilities in the state/federal VR system. Herbert and Cheatham (1988) observed that for the most part rehabilitation counselors are trained within the confines of a Eurocentric Counseling Model. The Eurocentric model connotes "a belief in the comparative

superiority of Anglo-American culture, in particular and in Euro-American culture, in general" (Jackson cited in Herbert and Cheatham, 1988, p. 51). "As such, it emphasizes Western European values, ethos, and beliefs, valuing mastery over nature, competition, individuation and theoretically, at least, it emphasizes rigid adherence to time" (Herbert and Cheatham, 1988, p. 51). Consequently, the history, culture, needs and interest of people of color are likely devalued and not adequately recognized as critical variables in the delivery of rehabilitation services.

Recommendations

1. Conduct research to determine which counseling approaches are most effective in delivering VR services to the various minority groups.

2. Conduct research to determine which VR counselors are most effective in delivering VR services to the various minorities groups (e.g., VR counselors with Master's degree in rehabilitation counseling, counselors with training in serving minorities, or more experienced VR counselors).

3. Fund research and training centers which devote their resources toward studying the needs of specific minority populations with disabilities.

4. Determine the training needs of state/federal VR agencies with regard to the delivery of services to minorities with disabilities.

5. Encourage rehabilitation counselor training programs to include specific courses pertaining to multicultural counseling and recommend the exposure of students to clinical training experiences involving minorities with disabilities.

6. RSA should continue to encourage the recruitment and training of underrepresented minority rehabilitation professionals in institutions of higher learning.

7. RSA should continue to fund colleges and universities with substantial enrollments of minorities in rehabilitation counselor training programs.

8. RSA should fund and encourage the participation of minorities in doctoral level rehabilitation counseling programs to increase the number of minority rehabilitation educators.

9. RSA should evaluate their policies pertaining to the delivery of services to minorities with rehabilitation.

10. RSA should evaluate the role of minorities professionals within state/federal VR programs to determine their role in establishing agency initiatives which impact upon minorities with disabilities.

11. RSA should increase the number of tribal operated VR programs to

increase the effectiveness of services provided to Native-Americans and Alaskan Natives.

Minorities with disabilities are in a situation of "double jeopardy" due to being a person from a minority group, coupled with the fact that many able-bodied persons (i.e., nondisabled persons) often perceive individuals with disabilities in a negative fashion. Rehabilitation as a profession should reach out to minorities with disabilities to aid their broader participation in American society. With the sincere efforts of all responsible parties, rehabilitation services available to people of color can be significantly improved.

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Reaction to The Vocational Rehabilitation of Minorities

Madan M. Kundu, Ph.D.
Rehabilitation Counseling
Southern University
Baton Rouge, LA

Dr. Giles, in his presentation, alerts us to issues of vocational rehabilitation (VR) services for minorities with disabilities. He focused on three major areas:

1. Problems encountered in accessing state-federal VR system by minorities with disabilities.

2. Lack of trained VR counselors who are minorities.

3. Comparison of state-federal VR system vs. private-for-profit rehabilitation programs.

Pertaining to the first issue, the author gave an excellent overview, with supporting data, which depicts the current status of minorities with disabilities in the United States. The state-federal VR system has made great strides in rehabilitating persons with disabilities since the inception of the program in 1920. However, the question of effectiveness in rehabilitating minorities with disabilities still persists. Dr. Giles diligently compared data on eligibility, ineligibility, number of services provided, time spent, and number of cases closed as rehabilitated.

With regard to the second issue, he depicted a dismal picture of educating qualified minority rehabilitation counselors in 110 NCRE and CORE accredited institutions and 117 historically Black colleges.

The third issue, public vs. private-for-profit rehabilitation services, is difficult to compare in the absence of available data based on empirical investigations. Private-for-profit rehabilitation represents the other side of the coin or a different facet of rehabilitation services. Consumers of private-for-profit rehabilitation are already employed and due to injury or illness in employment, they are referred by their employers, employee assistance programs, attorneys, insurance companies, and workers' compensation agencies. On the other hand, the majority of ethnic minorities with disabilities have individual and social barriers in accessing the public rehabilitation system. However, comparisons can be made on the following

dimensions: mode of delivery, types and quality of services, and outcome.

Response may be made on any dimension of the multifaceted issues raised by Dr. Giles. However, a few major issues will be discussed and pertinent recommendations will be made. The major thrust is that minorities with disabilities have an increased rate of ineligibility for VR services, eligibility determination takes longer, eligible individuals receive fewer services, rehabilitation process is long, and fewer cases are closed successfully.

The outcome of any social, behavioral, or rehabilitation intervention is a function of its participants and the internal and external social situation in which it operates (Fairweather & Tornzatzky, 1977). The rehabilitation outcome, in this instance, in the state-federal VR System should be viewed as a function of the participants, the rehabilitation clients who are minorities with disabilities.

The internal sociai situations in which these individuals are born, reared, quality of stimulation received, educated, and the environment they live in have a significant impact on the rehabilitation outcome. The external social situations in which minorities with disabilities are perceived, receive services, and those who provide services also have a significant impact on the rehabilitation outcome. The characteristics of the providers such as counselors, process variables, agency resources, mode of service delivery, and the philosophy of the agency have tremendous impact in the rehabilitation outcome. For example, counselor characteristics such as sex, race, education, perception and sensitivity to the needs of this special population, values, ethics, philosophy of service, and resourcefulness make a significant difference in rehabilitation outcomes.

This conglomerate of variables or factors interact in a multifaceted and complex way which ultimately determines the quality of rehabilitation outcomes. If we are indeed sincerely concerned with the plight of minorities with disabilities, then all the internal and external factors need to be addressed at the grassroots level using an holistic approach.

Kunce and Miller (1972) used a sample of 6,099 clients and cross validated on 3,995 clients who were closed cases by two Mid-Western state agencies. Race was one of the factors in the rehabilitation outcome. Atkins and Wright (1980) found significant statistical differences comparing Blacks and Whites on a number of dimensions throughout the rehabilitation process. Worral and Vandergoot (1980) used 6,263 closed cases of Oregon Vocational Rehabilitation clients during 1978. They have replicated the same study on 6,224 subjects in the same agency for cross validation purposes (Worral & Vandergoot, 1982). In both cases, among others, race was a predominant factor in rehabilitation outcome.

In an empirical investigation on active caseloads of clients and a six-month follow-up on post VR services in Louisiana, Michigan, and New York, Kundu (1983) found that on demographic characteristics, race was one of the major contributing factors to outcome. Stepwise discriminant analysis was significant in predicting VR

outcome, employed and unemployed, on four variables: race (Whites and non-Whites), number of dependents, secondary disability, and sources of support at referral.

Baldwin and Smith (1984) investigated the role of race and the impact socio-demographic variables have on the referral and rehabilitation process. Multiple regression analysis concluded that race had either a direct or indirect effect on the outcome. Findings of Kunce and Miller (1972), Atkins & Wright (1980), Worral and Vandergoot (1980, 1982), Kundu (1983), and Baldwin & Smith (1984) further validate the status of minorities with disabilities in the current VR system.

As the status of ethnic minorities with disabilities was established above and by Dr. Giles, let us focus our attention on the future. What are the prospects and challenges for these individuals as we rapidly approach the 21st Century?

Labor force projection for the year 2,000 (U.S. Department of Labor, 1987) indicate that:

* The proportion of Blacks, Asians, and others in the labor force will increase.

* Blacks will grow faster than Whites because of high birth rates.

* Asians and others will grow faster than Whites because of immigration and higher birth rates.

* The Hispanic labor force will rise from eight million to fourteen million in the year 2000. Growth will occur because of immigration and the rise in the native-born Hispanic population.

* The Hispanic share of the labor force will increase from seven percent in 1986 to 10% in 2,000. (p.11-12)

In 1989, the number of non-institutionalized Black and Hispanic of working-age disability was reported to be 3,523,000 Americans (U.S. Department of Commerce, 1989). If other ethnic minorities with disabilities such as Native Americans; Pacific Islanders, Americans of Asian, Chines, Cuban, Japanese, Korean, Puerto Rican, Vietnamese, and Arab descents are added, then the increasing trend in working-age disability among minorities in the year 2,000 would represent a significant percentage of the total labor force.

Is the state-federal VR system ready to accept these challenges of preparing a segment of the society who are economically disadvantaged, under educated, have limited training or skills, lack transportation, need increasing assistance in language, encounter attitudinal barriers, need job seeking and retention skills; while the jobs in the year 2000 will demand higher skill levels than ever before? The answer will be a mixed one. The State-federal VR system as well as other social institutions that serve these populations, needs an overhaul with innovative changes.

The traditional approach of educating, training, and employment assistance for ethnic minorities with disabilities has yielded limited success. Both individual attitudes and social institutions such as the VR system and other human services organizations must change (Hudson Institute, 1987).

Recommendations for State-Federal VR System:

1. Outreach: VR needs to develop and embark upon non-traditional outreach programs by developing linkages with community centers, churches, clubs, and social organizations where ethnic minorities participate actively and maintain their identity. For example, Black churches, Hispanic churches, Asian temples, and Indian Reservations are major sources to develop linkage. Church plays a vital role as community service organization and has a major influence on members providing emotional and motivational support. Churches, religious contacts (Hopkins, 1991), and inner-city community organizations can develop a network of information dissemination and on-going support activity in accessing VR services.

SPEED Model to Access, developed by Howard University Rehabilitation Project, is one such innovative approach. The model was replicated as Project Helping Hands, a client support model linking community and service agencies to outreach target populations (Wells & Banner, 1986). Similarly, Community-based Support Systems (King, 1986), Action-based Programming, and Information Center for Handicapped Individuals (ICHI) (Galiber, 1986) models need to be replicated across the nation.

2. Recruit qualified rehabilitation counselors, supervisors, state directors of various ethnic origins who possess extraordinary enthusiasm, expertise, and zeal in developing innovative outreach activities to serve as role models (Atkins, 1988). Representation of ethnic minorities in these decision and policy making positions are disproportional to the number of cross-cultural clients being served. For example, out of 82 state agencies (general and blind) in the country, only 5 states' directors are minorities. In Louisiana, out of 142 counselors, 22 are Black in addition to the state director. Similar data on counselors, supervisors, administrative staff, and other personnel were not available from RSA. These types of information would be of immense help in future interventions.

3. Develop in-service training modules to increase awareness, sensitivity, attitudinal shift/change on multi-cultural issues for counselors, supervisors, and administrators.

4. Develop and acquire resource materials such as books, journals, proceedings, other relevant literature, and make them available to agency personnel. A list of resource material is provided in the Appendix.

5. Initiate cultural awareness training for referral sources consisting of human services organizations such as SSDI, SSI, AFDC, FOOD STAMPS, etc. with a view to developing a sound network. Periodic education of the referral sources will

enhance accessing VR services by ethnic minorities with disabilities.

6. Encourage VR personnel to become members of special divisions such as National Association on Multicultural Rehabilitation Concerns of the National Rehabilitation Association, and Association for Multicultural Counseling and Development of the American Association for Counseling and Development.

7. Analyze service delivery patterns at statuses 02, 08, 26, 28, and 30 for ethnic minorities (Ross & Biggi, 1986) and develop strategies to eradicate current pitfalls and thereby increase rehabilitation rate. These analyses should be done at state, district, supervisory, and individual counselor levels.

8. Collaborate with local university rehabilitation counselor training programs in meeting educational needs on issues of multi-cultural counseling and local ethnic needs.

Recommendations for Rehabilitation Counselor Training Programs:

1. Outreach and promote recruitment of students and educators who are minorities and especially persons with disabilities who can serve as role models (Atkins, 1988).

2. Provide financial incentives such as graduate assistantships, scholarships, or fellowships in pursuit of their academic endeavors.

3. Infuse cultural diversity and ethnic-disability issues across curriculum with special emphasis on the following:

A. Current textbooks of counseling theory and technique focuses only on eurocentric counseling models. Two of the widely used texts, Current Psychotherapies (4th ed.) (Corsini & Wedding 1989) included a section on Asian Psychotherapies and Theory and Practice of Counseling and Psychotherapy (3rd ed.) discussed Ethical Issues in a Cross-Cultural Perspective in two pages (Corey, 1986). Ethnocentric counseling approaches are covered in such texts as Multicultural Issues in Counseling: New Approaches to Diversity (Lee & Richardson, 1991) and Counseling the Culturally Different (Sue & Sue, 1990) or other relevant materials need to be supplemented with current texts.

B. Casemanagement, Medical, Psychosocial Aspects of Disability, and Job Placement classes should incorporate exercises involving ethnic-disability case studies.

C. Standardized test instruments were basically developed for anglo-saxon populations. Ethno-centric or Afro-centric assessment instruments are limited or non-existent at this time. This is also true for persons with disabilities. The students in rehabilitation assessment and vocational evaluation classes must be made aware of the danger in the administration and interpretation of culturally biased tests for

persons who are culturally different.

D. Introduction to rehabilitation counseling class or field visits to community organizations would be of help in sensitizing students to ethnic-disability issues.

E. Practicum and internship activities are rich sources in gaining first-hand experience for students to learn about minorities with disabilities.

4. Develop leadership role by organizing workshops, seminars, and symposia on ethnic-disability issues involving students, faculty, professional counselors, personnel of human services organizations, and other community agencies with a view to provide community education.

5. Develop and acquire a list of resource material such as books, journals, proceedings on issues relevant to this special population, and make them available to students and faculty at the department or the university library. A list of resource material is provided in the Appendix. Ethnic minorities with disabilities: An annotated bibliography of rehabilitation literature (Wright & Emener, 1989) is an excellent and absorbing source which lists 526 references on Asian, African, Hispanic, and Native Americans with disabilities.

6. Encourage students and faculty to join the special division of NRA, National Association on Multicultural Rehabilitation Concerns, and AMCD, Association for Multicultural Counseling and Development.

7. Foster research on ethnic-disability related aspects by graduate students and faculty members which is an unexplored frontier.

Recommendations for RSA:

1. Out of 110 CORE accredited and NCRE member institutions and 117 historically Black colleges, only 9 minority institutions (Coppin State University, Fort Valley State College, Jackson State University, South Carolina State University, Southern University, University of Hawaii, University of Maryland-Eastern Shore, University of Puerto Rico, and University of Texas at Pan American) offer rehabilitation counselor training.

Historically, Black colleges and universities are often unable to generate matching funds. RSA must encourage, nurture, and assist in providing special grants to develop new rehabilitation counselor education training programs in minority institutions of higher learning.

2. The average percent of minority graduates over the last eight years in the U.S. is only 17.5%. RSA must increase the number of traineeship grants to universities to attract minority students in masters and doctoral programs, especially those with disabilities.

3. In order to develop a cadre of educators, researchers, and scholars, RSA grants should be targeted in developing doctoral studies.

4. RSA should take a proactive stance in assisting and implementing the recommendations made earlier for the state-federal VR system.

5. As an advocate, RSA must take an active part in incorporating the needs of ethnic minorities with disabilities in the ensuing reauthorization of the Rehabilitation Act.

Recommendations for NIDRR

1. Research and demonstration needs of ethnic minorities with disabilities should be given a national priority in the NIDRR funded research.

2. Implement research and demonstration projects in developing Afro-centric and ethno-centric models of: a. counseling, b. outreach, and c. service delivery.

3. Efficacy of service delivery by qualified rehabilitation counselors of same or different ethnic origins may be replicated across the country.

4. Develop a cadre of educators, researchers, and scholars who are ethnic minorities.

5. Utilize the expertise of ethnic minorities researchers and scholars in implementing NIDRR funded research and demonstration projects.

6. Provide special funding for masters thesis and doctoral dissertation research on issues of cross-cultural concerns.

In conclusion, a technologically advanced society as ours cannot advance further, leaving behind a staggering number of under-served populations or a segment of society who were traditionally being unserved. The "Melting Pot Theory" in America needs to be revisited with the "Cultural Mosaic Theory" in which the best from each culture or ethnic group will shine like precious gems and their combined glitter will replace the darkness of our minds, given adequate opportunity.

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Appendix
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Reaction to Vocational Rehabilitation of Minorities

Eddie E. Glenn, Ph.D., CRC, LPC
Rehabilitation Counseling Program
South Carolina State University
Orangeburg, SC

A review of the contents of the paper entitled "The Vocational Rehabilitation of Minorities" presented by Dr. Frank Giles indicates a crucial need for the Rehabilitation Services Administration (RSA) and the state/federal rehabilitation system to address the unique needs of "minorities with disabilities". The author clearly shows, with statistical data from the 1990 United States (U.S) Census Bureau records, that disabilities are disproportionately high among minority groups when compared with White Americans. In addition, there are demographic trends that illustrate that the number of minority persons with disabilities will continue to increase. As a result, there will be large numbers of minorities with disabilities of working age which will impact the RSA state/federal system. However, when the statistical data are closely examined, there are startling figures which illustrate otherwise.

Based on data from RSA along with data from the U.S. Census Bureau, there is a smaller number of minorities who: (a) have access to the federal/state vocational rehabilitation (VR) system; (b) move timely through the VR process and be rehabilitated with successful employment; (c) eligible for rehabilitation services, and (d) will not likely encounter a vocational rehabilitation counselor belonging to one of the minority groups.

The author explains why each minority group underutilizes the state/federal VR programs and why each minority group may be underrepresented. Several of the reasons are common to all of the minority groups, while others are unique to that particular minority group. Some of the reasons for the discrepancy in the statistical data concerning access and participation of minorities with disabilities in the state/federal VR program are that some: (a) members of the minority groups have a sense of mistrust and may demonstrate a lack of self initiative and commitment to VR services; (b) individuals from minority groups do not have sufficient or accurate information about VR services; (c) counselors have levels of lower expectations of members of minority groups (e.g. believe the disability does not represent a substantial barrier, with rehabilitation services will not lead to gainful employment, etc.); (e) counselor/client relationships are impaired by language and cultural

differences, racial/ethnic origin, migration vs. immigration and well as refugees vs. immigration, legal vs. illegal status and the amount of time spent in the United States; (f) possible recipients of services want to live in close proximity to services (lack of accessibility and availability i.e., rural areas, reservations, etc.); (g) individuals from some minority groups have close cultural and family connections and find it difficult to actively seek out societal services; (h) individuals from minority groups lack transportation to receive services as well as the ability to get back and forth to work if employed: (i) individuals from minority groups would like to be employed near their residences rather than far away; and (j) many of the VR counselors are White Americans and are not of a minority racial/ethnic origin.

In order for the RSA to address the unique needs of minorities with disabilities, the agency must reexamine its traditional approach to increasing the awareness of , understanding of, acceptance of, utilization of and commitment to VR services. However, it will take an action oriented commitment from RSA to mandate changes in the development and implementation of innovative nontradional delivery of services methods, such as, taking the services to the community, utilizing community leaders, including family support systems, etc.

Extensive field research needs to be funded by federal sources of qualified researchers who represent minority groups. These individuals would study the issues and develop assessment instruments to explore the issues with flexibility to include any additional issues identified in the actual field research. These instruments should be pilot-tested and designed to eliminate any barriers that may impede accessing this information. Methods of collecting information need to be concerned with the familial, cultural, community as well as language barriers. A thorough review of the collected research should provide information to develop and implement policies so that beneficial strategies and techniques can be created o influence more effective and efficient decisions concerning the: (a) location of services; (b) determination of eligibility for services; (c) movement of clients through the rehabilitation process; (d) matching of appropriate services to meet their unique needs; and (e) training (beyond awareness) for new and veterans rehabilitation personnel (i.e. from the federal level to the VR counselor) in working with individuals from diverse racial/ethnic groups. Hopefully, effective models can be developed for implementation.

There are several models which are available to improve service delivery and make services more available and accessible (i.e. Atkins' Asset-Oriented Model, Walker's Collaborative Model, etc.). These models, as well as any newly developed ones, should include both process and outcome measures.

There is also a shortage of qualified minorities working as professionals in the field of rehabilitation. The author states that among the institutions of higher learning, only about 15.8% of all graduates from rehabilitation programs are minorities. Also RSA must further expand its commitment to recruit more individuals from minority groups into rehabilitation counseling programs with training in multicultural counseling. To assist RSA in addressing the multicultural

issue, the agency should work with the Council on Rehabilitation Education to develop mandatory guidelines which will be implemented in the training programs to assure appropriate and adequate training of qualified rehabilitation graduates. RSA already has one vehicle to increase the number of qualified minority rehabilitation professionals. Several rehabilitation counseling programs are located in Historical Black Colleges and Universities (HBCUs). These institutions of higher learning are in a good position for RSA to provide funds for: (a) supporting the rehabilitation programs; (b) developing new rehabilitation programs; (c) providing funds for recruiting and maintaining more minorities; (d) including employment strategies so that more minorities will be hired into and promoted in the federal/state rehabilitation systems; and (e) creating incentives to increase the number of rehabilitation educators as well as professionals on the federal level and in state administrative positions. RSA must demonstrate that minorities must have a place in the field of rehabilitation from top federal administrative positions, where policy is developed, to rehabilitation professionals who supervise the administration of service delivery, to personnel who delivers direct services. In addition, all professionals in the field should be required to participate in extensive and continuous multicultural counseling. It is not just an awareness or a one time experience. Society changes with the times; therefore, it is important that all rehabilitation professional/personnel be prepared to work with individuals from diverse racial/ethnic populations.

There is limited information when comparing the state/federal VR programs and the private-for-profit system when focusing on the aforementioned issues relevant to minorities with disabilities in rehabilitation. Until more detailed research studies have been conducted to make adequate and appropriate comparisons only unconclusive results will be available. However, there is some data which can be used to make some limited statements about the two systems. Therefore, it is premature to develop meaningful comparisons which can be used to determine the effectiveness of each system.

The theme of this conference is "The Unique Needs of Minorities with Disabilities: Setting an Agenda for the Future." However, in reviewing this paper it is apparent that the rehabilitation field is not ready for 1995. There is a probability that the profession could be ready for the year 2000, but the field of rehabilitation must accept the challenge to be proactive rather than reactive.

PREVENTION

Prevention of Primary and Secondary Disabilities

Julie Clay
Rural Institute on Disabilities
University of Montana
Missoura, MT

"For the coming decade, perhaps no challenge is more compelling than that of equality... The relationships between poverty and health are complex and cannot be reduced to a simple one-to-one relationship between dollars available and level of health... While, from a public health perspective, the leverage available to effect improvements in education, job training, and other social services, improvements in education, job training, and other social services are necessary to erase the health effects of current income disparities." (Department of Health and Human Services, 1990, p. 91).

Healthy People 2000 reports that American Indians experience the highest percentage of major activity limitations among ethnic groups highlighted (13.4%). The number of American Indians under the age of 18, who have a disability is approximately 40,000, and about one third of American Indians over 18 years have a disability. Estimated rates of disabling conditions among Indians tend to be higher than any other group in the U.S., with rates six times higher than the general population. If the issues that face American Indians, especially those with disabilities, can be addressed adequately, it follows that other minorities will benefit.

Using the American Indian population as an example, I will cite personal stories which illustrate the need for change, make recommendations of how to introduce the concept of primary and secondary disabilities to the American Indian population, and finally discuss how to merge the national agenda for prevention with the Indian Health Service Round Table Recommendations for disabilities and their effects on American Indian and Alaskan Native Communities.

Four American Indians describe their experiences in dealing with a disability in the article, "Culture Shock: Waking Up in a Foreign Land," by Kristing Tower. Even though all four are members of the Shoshone tribe and have gone through the same rehabilitation facility, their stories each reflect a different set of life circumstances, which, in turn, point to various recommendations for change.

Mark Johnson, a Navajo/Shoshone artist, age 23, who drove his car off a cliff and broke his neck, says that catastrophe was only a matter of time. He realized he was on his way to disaster because of alcoholism and drug abuse. "At the age of 9 or 10, I had my first drink of wine... by the time I was 12 or 13, I was already gone." Alcohol abuse is the leading cause of car accidents for Native Americans.

Recommendation: Decrease the prevalence of disability caused by injuries and

chronic diseases such as diabetes and heart disease among the Indian population, including alcoholism and drug abuse.

Louis Hicks, a 27 year old Shoshone, left the rehabilitation hospital as a C5-6 quadriplegic, determined to return to his reservation in Nevada. Because of a lack of personal attendant services, home modification, out-patient therapy, public transportation, appropriate wheelchair technology, and a hospital unable to accommodate his needs, he found himself in a depression cycle which led to alcohol abuse and eventually landed him in an urban hospital. The lack of awareness about the needs of people with disabilities in his community drove him away. He then went to a nursing home in the city and finally found accessible housing. He stated that city life offered many more options for a person in a wheelchair such as being able to go to the store or the movies, having an attendant, or feeling secure in an emergency situation. In the city, he found other friends with disabilities with whom he could relate.

Hicks also talked about the difficulty of developing his spirituality after becoming injured. Before his injury, he told himself that his drinking and drug addiction was merely a phase, after which he would settle down and get into his religion. He intended to do sweats (purification rituals), fast, and participate in the Sun Dance. Now he wants to nurture his spiritual growth and realizes that he cannot be as active in it as he would like because of the highly physical demands of the dances, or the long hours of sitting in a steaming hot chamber during the sweat lodge ceremonies.

Recommendation: Insure that disability issues, especially prevention, receive attention and become a major priority among tribes through increased awareness, education and involvement of the Indian community and Indian leaders, especially tribal council members.

Rhonda Williams, a 23 year old Shoshone/Paiute who was injured at age 16, returned to her reservation as a C-67 quadriplegic. She was the only person with a disability on the reservation. She states, "I never thought I would be in this chair for long... When I finally realized I couldn't walk or use my fingers and hands, I couldn't stand the thought of it... I used to have to take salt pills because I cried so much." Deep depression set in, but she had a family that pushed her into resuming her role in the community.

Joe Cyperher, a 27 year old Paiute/Shoshone, was injured in a car accident that left him an L3–4 paraplegic. He is an urban Indian who has never lived on a reservation. His shock was not so much cultural as finding himself unable to continue as an airborne ranger. He stated: "One thing that got me through it was an old Indian story that compares God to a pottery maker in a market place. The potter would only go up to the strongest pots he made and tap on them with a metal bar to show people that his pots were strong, that they wouldn't break. I think God only taps on the strongest people, and I don't think any Native American should get down on themselves about their injuries."

Recommendation: Develop a community model of primary and secondary prevention for the Indian population inclusive of culturally relevant strategies.

Recommendation: Develop a surveillance instrument system to measure the incidence and prevalence of various disabilities among all ages within the Indian population.

Primary and secondary disability prevention issues related to the American Indian population have been on the fringes of a national focus during the past 15 years. The 1978 Amendment to the Rehabilitation Act brought disability issues to the forefront for American Indians by recognizing the need for culturally appropriate VR programs. Recent programs that serve Indian people on tribal land have become aware of their responsibility to get involved in disability issues. One such program, the Indian Health Service (IHS), is the primary health provider to Indian people living on tribal land. The goal of IHS is to "elevate the health status of American Indians and Alaska Natives to the highest level possible ensuring equity, availability, and accessibility of a comprehensive, high quality health care delivery system providing maximum involvement of American Indians and Alaska Natives in defining their health needs, setting health priorities for their local areas, and managing and controlling their health program." The IHS must become involved in the implementation of a national agenda for prevention because they are the principal federal health advocate for American indians.

The IHS has been searching for a role in the rehabilitation process for American Indians with disabilities and has started to recently define this role through a sponsored round table conference titled, "Disabilities and Their Effects on American Indians and Alaskan Native Communities." The goal of the roundtable was to bring together a group of informed professionals to discuss and analyze American Indian disability issues, and to address in written form, ways in which the IHS can improve its services to the people with disabilities. The result was consensus statements and recommendations addressing issues into four categories: (a) an IHS definition of disability; (b) Education, detection, prevention; (c) Service delivery approach; and (d) Information

Recommendation: Decrease the prevalence of disability caused by injuries and chronic diseases such as diabetes and heart disease by half among the American Indian population, including alcoholism and drug abuse.

Several consensus statements are noted from the IHS:

1. The consensus statement on the IHS definition of disability reads, "In order to improve the health status of American Indians and Alaskan Natives with disabilities, it is necessary that the Indian Health Service review and adopt an existing broad, comprehensive definition of disability within which tribes can develop their own culturally relevant definitions." The first step to a prevention program is adopting a broad definition of the topic which IHS points out in the above consensus statement.

2. Education, Detection, Prevention Consensus Statement: In order to establish a viable delivery system for American Indians and Alaskan Natives with disabilities, the IHS needs to improve awareness of disabilities among these populations through education, detection, and prevention.

Recommendation: Insure that disability issues, especially prevention receive attention and become a main priority among tribes through increased awareness, education and involvement of the Indian community and Indian leaders, especially tribal council members.

Recommendation: Develop a community model of primary and secondary prevention for the Indian population inclusive of culturally relevant strategy.

Within the American Indian population, spirituality is an integral part of wellness. Wellness consists of physical, spiritual, mental, and emotional health. Locust discuses three Indian spiritual beliefs that are held by several tribes and apply to health concepts: (a) wellness is harmony in body, mind, and spirit; (b) illness affects the mind and spirit as well as the body; and (c) each of us is responsible for our own wellness.

"One of the most serious problems in the delivery of Western medical care is that Western medical personnel tend to treat only the body and give little attention to the spirit. Understanding the events in a spiritual as well as physical sense, and then beginning the process of changing whatever it was in the body, mind, or spirit that was out of harmony is vital to achieve wellness. Sometimes the assistance of a medicine person is required to help the individual see the interplay between body, mind, and spirit, and to show how the spiritual needs affect the physical body, or mental state (e.g. being stressed). There is a lack of aids to assist the affected mind and spirit in facilities that serve Indians." It is important when introducing a new concept such as prevention of primary and secondary disabilities to integrate thee American Indian's cultural and spiritual beliefs. The American Health Care Association has developed a workbook, Healthy People 2000, for developing a community model which identifies objectives for the American Indian population. This model can be easily adapted when developing a community program for prevention of primary and secondary disabilities. Secondary disability prevention strategies can be identified and used by community members through a surveillance instrument such as the one developed by the Montana University Affiliated Rural Institute on Disability. This surveillance instrument was used to measure secondary disabilities among American Indians on three reservations in Montana. The Community Health Representatives (CAR) program was found to be the best approach in securing information regarding the health needs of the Indian people. The CHRs were instrumental in the dissemination of the survey tool.

Chronic conditions reported by Hodge (1990) have recently come to be referred to as secondary disabilities and have attracted the attention of disability advocates (National Council on Disability, 1986; 1988). For example, in a preliminary study of the needs of American Indians with disabilities, Hedge reported a high

frequency of 17 health problems (e.g., alcohol abuse/dependency, high blood pressure, arthritis) among disabled American Indians who live on three reservations. Seventy-five percent of the respondents worried most about health conditions and further loss of ability. Another essential component for the introduction and acceptance of a new concept is to involve the people at all levels of the structure as indicated below.

3. Service Delivery Approach Consensus Statement: The IHS should develop a policy and structure to plan for and deliver services to American Indians and Alaskan Natives with disabilities including defining roles and responsibilities of persons with disabilities, their families, communities, and tribes.

Recommendation: Develop a surveillance instrument system to measure the incidence and prevalence of various disabilities among all ages within the Indian population.

In general, public health has met the health needs of the mass population by depending on an effective and sensitive surveillance system which, in turn has provided essential and useful services and programs to discern the public health needs of the population. In order to implement a prevention agenda tailored to meet the unique needs of American Indians, a surveillance system has to be in place. As mentioned in the IHS Information Consensus Statement, a method of collecting and disseminating information on disabilities will improve services for American Indians with disabilities.

4. Information Consensus Statement: The IHS should assume the responsibility for collecting and analyzing information affecting American Indians and Alaskan Natives with disabilities. The IHS should disseminate this information to IHS personnel, other governmental agencies (tribal, federal, state) Indian communities (including Indians with disabilities, their parents and families) and other individuals and organizations.

The majority of these recommendations addresses disabilities and their effect on American Indians are discussed in Disability in America, which outlines a model for a national agenda on disability prevention. The IHS roundtable meeting final report does not refer to a national agenda, thus one might assume a failure on the national level to include American Indians in the development of a national agenda for prevention. Strategies need to be developed in which American Indians and other minorities can be included in the implementation phase of a national agenda for prevention immediately. This will ensure that the minority population will have a voice in the development of programs aimed at their particular population. A method to include minorities in all five strategies needs to be researched and achieved.

Reaction to Prevention of Primary and Secondary Disabilities

Katherine A. Williams, Chief
Office of Disability Affairs
Consumer and Regulatory Affairs
Washington, DC

The paper entitled "Prevention of Primary and Secondary Disabilities" discusses two concepts that are critical if effective programs are to be developed to meet the unique needs of minorities with disabilities. The two critical concepts focus on: (a) the need for change in service delivery models for minorities with disabilities; and (b) the need to prioritize prevention in program development for disabled minorities. I strongly endorse these two concepts as recommendations to be considered in setting an agenda for the future in the provision of services to minorities with disabilities.

Prevention should be the leading priority in the development of health care programs for minorities. Not only is this the right thing to do for Americans, but over a period of time would prove to be cost effective. The public funds that would evolve from intense prevention programs could be used to initiate new effective service delivery models.

Redirection of resources should be an immediate goal for federal and state programs serving people with disabilities. Program development follows federal funding streams and the current pattern is fragmented among various agencies. This fragmentation discourages expansion of prevention programs that would meet the needs of minorities.

Non-traditional approaches of service delivery should be encouraged by federal and state governments. The increase of primary and secondary disabilities among minorities is evidence that current preventive programs need to be enhanced. The following factors that impact our society should be considered when developing non-traditional approaches to service delivery for minorities:

* Changes in the family structure
* Increased urbanization by minorities
* Increase in culturally diverse communities

* Continued isolation of minorities in rural areas.

Non-traditional approaches to developing prevention programs for minorities should focus on increased awareness and education, and be culturally specific.

Continued advocacy is needed to develop programs that meet the unique needs of minorities with disabilities.

Reaction to Prevention of Primary and Secondary Disabilities

Larry Burt
Program Manager
Disabilities Prevention Program
Centers for Disease Control
Atlanta, GA

I want to thank the National Council on Disability for inviting me to be a reactor to Ms. Clay's paper.

My reaction is based upon my review and 27 years in public health, the last four with the Disabilities Prevention Program, and 27 years of experience as a parent of a son with a developmental disability. While I do not think there is any conflict, please understand that my comments today reflect my personal viewpoint and does not necessarily reflect the position and endorsement of the Centers for Disease Control (CDC).

Ms. Clay's paper presents the aspects of disabilities in the minoriity group that she knows best - American Indians. Additionally she illustrates her paper with personal stories that causes the reader to see the faces of disability and not just the numbers. I concur that if the issues that face American Indians with disabilities can be addressed, then other minority groups will benefit. I also feel this is true for any minority group with disabilities.

Allow me to share several specific comments on this paper. First, I wish to expand the information regarding the prevalence of disabilities beyond Native Americans to other minority groups. American Indians have the highest rate of activity limitations (17.8%) followed by Black non-Hispanics (14.9%). This compares with 14.5% in White non-Hispanics and 6.4% in Asians and Pacific Islanders. Black (non-Hispanics) have the highest proportion of people with disabilities who are unable to perform major activities (5.5%) while Native Americans have the highest portion of disabilities in the amount or kind of major activity (8.2%). When grouped, without regard for Hispanic or non-Hispanic origins, the prevalence of activity limitations among Blacks is 16.3% compared with 112.8% in Whites. [2]

Second, Ms. Clay recommends decreasing the prevalence of disabilities cauused by injuries and chronic diseases among the Indian population. I suggest that the emphasis should be on reducing the incidence of disabilities rather than the prevalence of disabilities. When we address the incidence, we address the injuries,

diseases and environmental factors that cause or contribute to new disabilities. Reducing the new occurrences will eventually over a period of time reduce the prevalence. If we emphasize reducing the prevalence, we include the persons with disabilities along with the injuries, diseases and environmental factors. Reducing the incidennce or prevalennce of disabilities must be targeted toward the causes of disabilities not the persons with disabilities. This applies to all population groups.

My third comment relates to the recommendation to insure that disability issues, especially prevention, receive attention and become a main priority area among tribes. The author lists increased awareness, education, and involvement of the community and community leaders as ways to prioritze these issues. In order to increase the awareness and to educate the community, we must be knowledgeable of the many variables that lead to disability and have an understanding of the many manifestations of disability.

Public health surveillance, in addition to counting the numbers, is how we identify the risk factors, magnitude of risk, and the degree to which risk can be controlled for any public health concern. Public health surveillance should also help us determine the many complex interactions that occur along the continuum from pathology to impairment to functional limitation to disability. The knowledge gained from public health surveillance will permit us to develop effective preventive interventions; to educate the community and community leaders and increase their awareness and understanding of disabilities in the community; and, make disability issues a prioriity area in any minority population or community.

Cultural sensitivity is the fourth category for comment. The consumers of public health, the communitty or public, is made up of diverse cultures. The Disabilities Prevention Program at the CDC includes persons with disabilities in the development of prevention strategies and encourages state grantees to insure the involvement of persons with disabilities in the development of state prevention programs. This involvement must be afforded members of the various cultures to which interventions are directeed.

In addition to public health prevention being culturally relevant, it is important for the various cultures to explore culturally acceptable alternatives to address situations that can not be modified. For example, Ms. Clay relates the story of the Shoshone who is unable to participate in "sweats" because of his quadriplegia. Is it possible that an alternative could be developed that is acceptable to Shoshone religion that would allow this young man to nurture his spiritual growth?

Fifth is family support. Personally, I do not feel that the issue of family support can ever be over emphasized. The National Council on Disability recognized the importance of the family to the point that they sponsored an entire national conference on this issue in 1989. It is my opinion that, from a scientific basis, the positive influence that family support has upon the person with a disability, as well as, the financial and emotional impact and disruptive influence of disabilities upon the family is not well understood nor appreciated.

My sixth and final comment addresses the issue of a national plan for the prevention of disailities. The National Council On Disability has advocated the development of a national plan for prevention since the mid-eighties. The Disabilities Prevention Program is supportive of that effort. Since its inception the Disabilities Prevention Program has been collaborating with the Council, other federal agencies, and public and private organizations to gather the information necessary for developing a national plan.

The Disabilities Prevention Program and the Council have taken the initiative for developing this plan. To be a national plan, it will require the input of many federal agencies, public and private organizations, persons with disabilities and their advocacy groups, and representatives of minority groups among others. Development of the plan will not be a quick process due to the size and diversity of the stakeholders. It can be done and to the best of our ability will include all groups in the process.

Thank you.

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EMPOWERMENT

Empowerment and Minorities with Disabilities

Eva P. Britt, Staff Attorney
Information, Protection, and Advocacy Center
for Handicapped Individuals, Inc. (IPACHI)
Washington, DC

We, in the United States, are faced with a dilemma of staggering seriousness. Our minority citizens with disabilities are born identified as a minority within a minority. They suffer and are ignored. They are disenfranchised, discriminated against, and are dying physically and spiritually; they are hungry, unclothed, unemployed, unsheltered, and completely unaware of the quality of life which is their constitutional right and guarantee.

In the last three decades, in an effort to express the growing concern for persons with disabilities, our society has thrust itself deeply into the area of personal rehabilitation. This concern has been evidenced nowhere more strongly than in legislation which has resulted in programs designed to help the people with disabilities. Implementation of these laws clearly require outreach so that African Americans and other minorities can share these rights and have their ways of life respected and incorporated into community-based social service programs, or into institutional service programs. However, as a result of the historical climate, with its ever-present racism, African Americans and other minorities are over-represented in every statistical indicator of lower socio-economic status and poor health. Many minority persons have continuous and periodic episodes of acute anxiety attacks, depression, and personality disorders.

Members of the African American and other minority disability groups have been and continue to be isolated from the mainstream of service delivery systems and experience great difficulty in locating and accessing services. Social service professionals who are predominantly non-minority, traditionally show concern for the problems of African Americans and other minority persons with disabilities, but more often than not, this concern has been patronizing and self-fulfilling of the needs of the majority society rather than of African Americans and other minority groups.

Over the past 20 years, the developmental disabilities movement has been a growing part of American life. Families with members with developmental disabilities have been demanding more appropriate services. Negative attitudes toward persons with developmental disabilities have been changing and society is beginning to recognize that these individuals have the right to acquire education, job

skills, and to lead fully integrated and productive lives. The Americans with Disabilities Act (ADA) of 1990 can and should be credited with bringing to full light, the needs, interests, wants, and desires of all persons with disabilities. However, due to racial, attitudinal, language, economic, geographic, and transportation barriers which remain in spite of this sweeping legislation to fully integrate persons with disabilities into the mainstream of society, African Americans and other minority persons with disabilities continue to be systematically excluded from obtaining the health and human services to which they are entitled. These minority groups will be further alienated from the service delivery system because of barriers such as cultural and subcultural dynamics, and more specifically, beliefs, biases, perceptions and values.

In addition to these physical, economic and psychological barriers, there is a lack of genetic counseling and testing and a lack of accessible housing available to minority persons with developmental disabilities. These obstacles create a reluctance among African Americans and other minorities to interact with non-minorities. African Americans and other minority persons with developmental disabilities often also lack basic knowledge of their rights and protections under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the newly enacted ADA. African Americans and other minority persons with disabilities are not aware of the protection and advocacy systems as mandated by Public Law 101-496, The Developmental Disabilities Assistance and Bill of Rights Act of 1990, and Public Law 101-173, The Protection and Advocacy of Individuals with Mental Illness Amendment Act of 1991. These laws provide free advocacy and legal services to persons with mental and developmental disabilities.

It is a historical fact that African Americans and other minority persons with developmental disabilities are underserved or even unserved by health and human service provider agencies throughout the country. Health and human service agencies, in addition to being staffed by predominately White providers, generally are not well versed or familiar with the provisions of Title VI of the Civil Rights Act, or with the Rehabilitation Act, or even with ADA. As a result, most are habitually out of compliance with these laws.

There is a paucity of bilingual personnel and a lack of accurate data on the racial/ethnic backgrounds of the clients with developmental disabilities served. Agencies do not institute outreach programs to encourage participation of African Americans and other minority persons with developmental disabilities. And, there exists a minimal number of African American professionals trained to work in the area of developmental disabilities.

In 1980, the Minority Affairs Committee of the National Association of Protection and Advocacy Systems influenced the Civil Rights and the Administration on Developmental Disabilities to fund seven protection and advocacy systems to provide outreach service to ethnic minority persons with developmental disabilities: California - Asians; Arizona and New Mexico - Native Americans; Texas - Rural Mexican Americans; District of Columbia - Urban Hispanics; West Virginia - Rural

African Americans; and Maryland - Urban African Americans. These projects made significant gains in identifying and assisting ethnic minority persons with developmental disabilities in obtaining appropriate health and human services. Materials were developed in native languages and training was provided to service providers, parents and consumers on legal and social entitlements.

Today, we face major budget reductions in areas that severely impact persons with disabilities, particularly African Americans and other minorities. Let me share some information regarding the present health of African American children in this country.

The National Black Child Development Institute found that African American children are much more likely to suffer from poor health than the majority of their American peers. While poverty, unsafe housing, poor nutrition, and teenage pregnancy expose many African American children to harmful and hazardous conditions, their plight is compounded by systematic inaccessibility to competent health care. Together these factors make many African American children a population substantially at risk with few resources for assistance.

The statistics detailing the effects of deteriorating environments are particularly grim. The National Center for Health Statistics found that African American infants are twice as likely as white infants to die before their first birthday. An African American child has a 30% greater probability of dying by his/her 14th birthday than does a White child. African American children who live in poverty will miss an average of three days a year from school due to acute illness than will higher-income children. Indeed, an African American child living in deteriorating housing will have a 25% chance of having excessively high levels of lead in his/her teeth and blood even today.

Given the greater susceptibility of poor children to serious health complications, the relative inaccessibility of many African American children to competent medical care is disturbing and disgraceful. Over 40% of all African American children, compared to 29% of Whites, do not see a single physician each year. Even worse, 17% of all African American children have no regular place of care despite their strong possibility of poor health. (If one considers that 30% of all African American children use only institutional care, the dissimilarities become more explainable.) Families without a regular physician cannot receive care that is integral to effective preventive medicine. African American children, as a result, are much more likely not to receive basic immunizations against childhood diseases. Less than half of all African American children have received three polio dosages as medically recommended, and only 58% of African American children have ever received an inoculation against measles. Thus, African American children are 25% more prone to measles infections than are their White counterparts.

No statistic captures better the hazard of being born African American than the exceptionally high incidence of infant mortality. Even though the infant mortality rate in 1976 for African Americans was 25.5 deaths per 1,000 births and continued a

steady downward trend,White babies born twenty-five years earlier had the same chance for survival! More than any other factor, the delay or the absence of prenatal care accounts for high incidences of infant mortality since early health problems can go undetected without proper prenatal care. For each month of pregnancy, African American women again are twice as likely to have not obtained prenatal care. Should a mother go without effective prenatal care, she will then be three times more likely to bear an underweight baby susceptible to infant mortality, prematurity, mental retardation and malnutrition. The fact that over 13% of all African American babies are born with low birth weights is a dramatic reminder of the poor health that plagues many African American children from the cradle on through adulthood. Due to inadequate health information and accessibility, African American adolescent mothers are the group most likely not to receive prenatal care or else, to delay it until the last three months of pregnancy. Therefore, as many as 20% of all births to African American teenagers result in low birth weights.

It was an ironic tragedy that in the International Year of the Disabled Person (1981), the Reagan Administration called for broad-based reductions of federal support for primary service systems such as social security disability insurance, medicaid, medicare, vocational rehabilitation, developmental disability programs, mental health services and education for children with disabilities. The veto of the reappropriation of the defense budget excess to social service programs recently tendered by President Bush is evidence of the lack of priority for social service programs. The combined results of proposed budget cuts on people with disabilities and their families will have devastating effects. Many people with disabilities are now barely coping with the multiple strains in their lives face new levels of psychological, as well as family and financial difficulties. Significant numbers of persons with disabilities, especially African Americans and other minorities will continue to fall through the cracks. Health problems will increase, as well as the frequency of hospitalization. More persons with disabilities will be unemployed and more will be forced into a welfare status. Greatly increased competition at the local and state level for reduced program services will become a divisive factor in community life. Vulnerable groups will be pitted against each other in a struggle to satisfy needs with more limited resources. The effect on minorities with disabilities, given their intense vulnerability, will likely result in much greater isolation and increased dependence.

Creative solutions are demanded. The "New Federalism" of non-involvement and restraint has its roots in racism - a racism which burdens the African American and other minorities with disabilities with societal stereotypes based on their race and socio-economic background - has set a tone for less money, less technical assistance, and less broad-based rights and due process protections that were previously considered, if only in theory, sacrosanct from the strains of competing economic interests and hidden state agendas.

Solutions must be implemented now which will include the involvement of African Americans and other minorities with disabilities who have knowledge of the issues, who are sensitive and who are committed to meeting the needs of African

Americans and other minority persons with disabilities. A valuable resource can be found in organizations such as the State Protection and Advocacy Systems, State Mental Health Administrations, State Developmental Councils, as well as private industry, volunteer advocacy groups and coalitions of concerned citizens. Establishing and monitoring such a network between the various groups will, in effect, create a force that must be dealt with. These organizations must become information and empowerment centers and "Think Tanks" for the minority disability movement. These organizations must reach out and make real and meaningful to all, the laws and regulations currently on the books that serve persons with disabilities.

"Where were the minorities in the disability movement", you ask? Where they have been throughout the course of history in this country, - attempting to survive the ravages of racism, poverty, disenfranchisement and disunity. The minority disability movement is only now taking form within the rubric of American Society.

Reaction to Empowerment and Minorities with Disabilities

Nellie K. Gainer, ADA Consultant
Peer and Family Project on the
Americans with Disabilities Act (ADA)
College Park, GA

Minorities as a whole are disenfranchised, discriminated against and are dying spiritually as well as physically. This is evidenced by the reactions of people, in various parts of the country, to the police trial in California. People are tired of being relegated to the back of the bus. We had hoped that we had straightened out Jim Crow justice in the 50's and 60's. But by the verdict, issued by that jury, let it be known to the whole country, that things have not changed. The resulting riots demonstrated the frustrations of minority communities.

One can only imagine what the level of frustration is for minorities with disabilities. Members of minorities with disabilities have always been isolated. They have always been kept separate without any effort towards equality. The very nature of society's reaction to disabilities produces isolation. I was a member of the first special education class for African American children in Atlanta, Georgia. There had been a school for White children with cerebral palsy for a number of years, but we were not allowed to attend. At the "White School" the children got physical and speech therapy every day. We, on the other hand, received therapy once a week. We were aware of the differences in treatment and discussed it. However, we were lucky that we had a very nurturing person as our teacher. She empowered us when she told us we were just as good as anyone. She empowered us by giving us as many and varied experiences as she possibly could. She empowered us by letting us take risks and holding us accountable for our actions.

Empowerment is a very exciting word. It means to authorize. There are three words contained within this word that are exciting within themselves. Power, we and me. To paraphrase a saying "You can't empower someone without empowering yourself." I think my elementary school teacher knew this when she allowed us to help teach the children in the grades under us. She was reinforcing what we had already learned.

Minorities have a history of taking care of their own. While that is admirable in some respects, it has not always been good. The community rallies around families with members with disabilities, and the families tend not to reach outside that circle to inquire about services that might be available to them. The service delivery system has traditionally been predominately White and male. They don't

understand the way minorities function within their communities, and for the most part, do not want to understand. When members of the minority community decide to venture outside of their communities to access services, they are often met with hostility and an unending bureaucracy. Most members of the minority communities don't speak in bureaucratic language, and some don't even speak English. American society is unforgiving of those that do not speak their language. When faced with these dilemmas, it is easier for minorities to retreat back into their communities of isolation and feel safe, rather than risk humiliation. Which is what the majority, (White) community want anyway. They don't want to have to deal with minorities, and therefore, they won't have to share their resources.

What is required of us now is to redouble our efforts. The few members of the minority communities that have made it into the mainstream of society must reach back and bring others along. We must make a concerted effort to go into the schools and educate the children as to what their rights are. It is not enough to educate the parents, we must educate the kids. Most minority kids with disabilities don't get a real sense of themselves and their value to society. The word "consumer" says a lot about what society expects of people with disabilities. It implies that we are users and have little to offer. We must change our terminology. We must provide information, let the people know what the important issues are. Encourage them to voice their opinions, and stand behind what they believe is right. Let the people know what is available to them, let them know what society says their limits are and encourage them to prove society wrong. Tell them how they can access the goods and services that are available, there is a need to make it as easy as possible for them to do so.

The most empowering thing I've done for myself was to go to jail last October with my fellow ADAPT (American Disabled for Attendant Programs Today) members. I put myself and my safety on the line for something I believe in. Most people in White society that watch the news regularly on television would find it hard to believe that the worst thing a member of an African American family can do is go to jail. But, one of the best things you can do is go to jail for a cause you believe in. I went to jail because I believe in the right of personal assistance services being made available to everyone that needs it. Furthermore, it must be a service that is controlled by the person with the disability. The person with the disability must make the decision as to what they need and who is going to provide it. And, these services will be paid for by the federal government. When this happens, we can truly say "Power to the People." Because, "People United Will Never Be Defeated!!!"

Reaction to Empowerment and Minorities with Disabilities

Cheryl Wu, M.A., Coordinator
Hearing Impaired Program (HIP)
Big Brothers/Big Sisters of S.F.
San Francisco, CA

I would like first to compliment Ms. Britt for presenting such an excellent and powerful overview of the tragic realities that face our multicultural population groups, in particular those with disabilities.

Based on over 13 years of work experience with multicultural groups with disabilities in special education, social service and mental health, I feel I can best approach this topic of empowerment from being a direct service provider where the process of empowerment takes place through direct and personal communication and interaction with my clients and their families on a day to day basis. As service providers, we work with persons with disabilities to enhance their lives, provide support and enable them to cope more effectively with whatever their needs may be.

For multicultural families with a member with a disability, the empowerment process must begin with an agency/organization which is culturally, linguistically, and operationally accessible to the family. The provider must have **multicultural skills** which are adequate to effectively communicate accurate information regarding the particular disability with sensitivity to the family's cultural background. Subsequently, any diagnostic evaluations or intake assessments must also be conducted and conclusions drawn within the appropriate cultural framework. This will facilitate the therapeutic, and/or social and/or educational services which **affect not only the client, but the client's family as well.**

In most northern and western regions of Europe and North America, there is a cultural orientation toward individualism. This is in great contrast to many of the countries in Asia, Africa, Latin America, and the Pacific where emphasis is on "collectivism" (Triandis, Brislin, & Hui, 1988). The implication for practitioners begins with approaching the multicultural client with disability in the context of the family, cultural community and larger society, and **not in the isolation** of the individual's environment. It is critical to engage and involve the family at all levels of service, education, program development, and legal advocacy processes.

In the Hearing Impaired Program which I currently direct out of San

Francisco's Big Brother/Big Sister Agency, 99% of my client caseload are from multicultural backgrounds. In nearly 75% of these households, a language other than English is used as the primary language. In cases in where the family speaks English, it is often extremely limited. For many of these families, who are recent immigrants to the U. S., they are immediately challenged by a "triple minority" status. First, they must cope with how to maintain their own cultural traditions and language. Secondly, they must learn a new culture (American) and language, English. Lastly, they must encounter a third community and culture of the American deaf and American sign language.

Unfortunately, for the majority of the families I serve, they are often unable to access any other assistance or support service from within their own cultural communities, or the deaf community of professional agencies and organizations in the Bay Area. The problem is rather simple -- neither community (ethnic or deaf) knows enough about the other to be able to adequately serve the multicultural non-English speaking family with a deaf/hearing impaired child. For the deaf community, the problem is a lack of multicultural awareness, respect, and multi-linguistic inaccessibility. For the racial/ethnic communities, the problem is the lack of deaf awareness, understanding and sign language skills. This example illustrates that effective service delivery requires agencies to provide not only bilingual personnel, but that service agencies must be multi-lingually accessible. Service providers must become multiculturally competent if they are to meet the complex needs of the rising numbers of multicultural families of people with disabilities. This requirement applies to the country, and not just in major urban cities such as San Francisco or Los Angeles. In addition there is a need to establish collaborative and cooperative relationships among multi-ethnic non-disabled communities and disabled communities in order to educate one another and share resources.

Ms. Britt noted in her opening statement that over 10% of the world's population is mentally or physically disabled. The statistic, used by audiologists, for the number of deaf and hearing-impaired in the U. S., is estimated at already over 8%. This number is expected to be even higher in foreign countries where there is inadequate health care and support services in comparison to those in the U. S. However, it should also be noted that, similar to other demographic statistics regarding disabilities in the U. S., the statistic for deaf and hearing-impaired people is probably an underestimate of the actual number of individuals. Considering the number of multicultural families, the actual number is even more due to the many cultural, social, economic, legal, and immigration issues which are likely to prevent a family (who has recently immigrated to the U.S.) from reporting or seeking help from public services.

Furthermore, we must not forget to take into consideration those who have multiple disabilities. These individuals are terribly undercounted, underserved and at times unserved due to being forced to identify with only one disability category or another. Consequently, these individuals are denied their complete identity, and have several needs which go unattended. One can only imagine that the situation for multicultural individuals with multiple disabilities is a great deal worse. They on the

other hand, are not likely to be less counted and recognized. In our present state of the economy, when money is becoming increasingly difficult to attain for developing more service programs, being undercounted or not means going unrecognized. This results in not being able to get the funding necessary to establish service programs which would support these individuals.

We have learned a great deal from Ms. Britt about African Americans and those who have developmental disabilities. It is equally important to be aware of the many other sub-groups within the disabled community at large who also experience similar conditions and inequities in our system. Unfortunately however, those of us who are connected to the various groups - whether we are professionals, advocates, or consumers, too often are competing with one another for the limited resources. If we are to adequately meet the needs of all communities with disabilities in an inclusive, rather than exclusive manner, and particularly those within these communities who are at greater disadvantage, such as minority individuals, then we can no longer afford to compete with each other and need to work collaboratively to maximize resources.

It is necessary to recognize that the racism within the non-disabled white establishment and non-disabled multicultural groups also exists among the various sub--groups of white individuals with disabilities and multicultural individuals with disabilities. Low-incidence disabilities, such as deafness and hearing-impairment, are already very vulnerable to discrimination from within the disabled community at large. The "triple whammy" effect applies to deaf and hearing-impaired individuals who are also multicultural and may be at an even greater disadvantage to experience neglect, by both the American deaf communities and the larger disabled community. Prior to this conference, the disabled community at large has not adequately addressed the issues of minorities with disabilities. Also, only within the last four to five years have American deaf communities and professionals in deafness finally started to give attention to the needs and issues facing multicultural deaf individuals and their families. An important outcome of this Conference is a recognition of the need to build a sense of disability identity and enablement within the community and simultaneously establish linkages which bridge communities together rather than separate them; in addition , this Conference encourages the rehabilitation community to view this situation is a "systems" perspective in which a multicultural individual with disabilities is seen in the context and relation to his home/environment/family, his particular disability's culture and/or community, his/her particular ethnic community, and the greater society at large.

Ms. Britt commented earlier on the sweeping legislation of the 1990 ADA. Its language and intent promote the concept of working together for all people with disabilities. However, the weakness of it may lie in its broad based language which may not require enough specifics to ensure full accessibility, protection, and rights to individual with disabilities who often go uncounted, and unrecognized, and have very little support in terms of program services. These individuals include multicultural individuals with disabilities and their families. It is important that we work together to maintain the unity of the disabled community at large, while at the

same time recognizing and celebrating the diversity of each sub-group. This will insure that the critical and unique needs of a particular group are not overlooked and neglected.

Ms. Britt's comment on the lack of genetic counseling and testing of the minority population brought to mind the lack of multiculturally appropriate diagnostic and assessment tests and evaluations currently in areas such as mental health and special education. I have seen too many clients misdiagnosed (e.g., DSM-III and/or special education categories) unnecessarily hospitalized, and often approached using ineffective, culturally irrelevant and insensitive treatment methods or plans. This, in my perspective, is not only unfortunate, but inexcusable and intolerable considering that multicultural awareness and practical application of available knowledge may easily prevent such incidences from occurring.

The fact that multicultural individuals with disabilities often lack basic knowledge of their rights also holds true for their families -- particularly in multicultural parents of younger children with disabilities. These families often come from other countries to the U.S. for the sake of their children with disabilities only to be awkwardly confronted and overwhelmed by the American service delivery systems and values that focus on individualism, personal freedom and individual rights. These systems may be in conflict with their own cultural values and ways of life. For these families, there is a need for more legislation that is culturally sensitive, respectful, and addresses the rights and advocacy issues for the multicultural families and their racial/ethnic communities, as well as the focus on individual rights and protections.

The empowerment process must not only take place within the individual, the family and their communities, but also with the professionals who serve these individuals. Ms. Britt acknowledged the sad fact that there is a tremendous lack of multicultural professionals trained to work with people with disabilities. However, an even greater void in our systems is that there are fewer individuals with disabilities and multicultural status serving as professionals within the field. There is much to be said for empowerment, but if multicultural individuals with disabilities can not have access to service providers who are from similar or same backgrounds as themselves or trained in multicultural issues, and do not see themselves in professional fields or positions of leadership and status, than all of our talk about adequate accessibility and equal opportunity is just "talk" and provides nothing of significance to these individuals.

In conclusion, the implications to practitioners, to multicultural communities, to the disability communities, and to the society at large in the U.S. are several. There are no easy "short cuts" or remedies. The process of empowerment remains dynamic and on-going over time within the context of interrelations among individuals with disabilities, the family, the communities, and the larger society. To possess only the multicultural awareness, knowledge, sensitivity, and respect and/or to possess all the knowledge of a particular disability is not enough and of little value to those whom we are addressing at this Conference today. We must apply

what we learn to dialogue with one another and to develop definitive action steps to bring about the necessary changes in our legal, educational, and service delivery systems which will work to bring about empowerment of people with disabilities.

To work more effectively, and with greater respect and understanding of one another, we must engage in an on-going process of analyzing our own racial attitudes, stereotypes, and perceptions of others who are different from ourselves, and move forward to becoming more adaptable and flexible in how we relate to one another. Likewise, our service agencies, organizations and institutions must also examine themselves to assess their culture, operations, and staffing in relation to the multicultural clients whom they serve. Among the questions which they must address are: In what ways do we serve these individuals and their families effectively? In what areas do we fail them? How well do we recognize our clients and their family's strengths and qualities? How do we utilize their strengths to enable us to work more effectively with them? Do we tend to preoccupy ourselves in criticizing these families and/or parents whom we do not understand or communicate with (for their dysfunctions or faults which we have concluded they possess based on our own racial/ethnic biases and limited multicultural knowledge and understanding? If we have not begun to dialogue with our ethnic communities, we should initiate such outreach and building of new alliances, information and resource sharing, collaborative and cooperative teamwork. We must strive to develop innovative and creative programs which are built upon a foundation on which multicultural sensitivity, respect and accessibility results in empowerment.

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PHYSICAL HEALTH

Minorities, Physical Health and Disability

Anita Leal, Ph.D., Director*
Employee Support Program
Universiity of California, Santa Cruz
Santa Cruz, CA

The physical health status of minorities in the United States (U.S.) is still poorer than that of the general population. In particular, African Americans (i.e. Blacks), Latinos (i.e. Hispanics), and Native Americans endure an excessive amount of illness and death. (We know the least about the health status of Asian Americans and Pacific Islanders.) Minorities are especially at risk to develop disabilities that limit their ability to participate in the workforce. In general, disabilities will have a deleterious effect on the quality of their lives.

Poor physical health and disability are inextricably connected: one either precedes, proceeds and/or interposes the other. Theoretically, a person with a disability can be in good health. However, in actuality, a great number of people who are in poor health have some disability and a great number of people with disabilities are in poor health (Ries & Brown, 1991). Even though we've known for decades of the poor physical health status of minorities and hence their vulnerability to disability, we know virtually nothing about the following:

1. What is the physical health status of minorities with disabilities?

2. What is the experience of minorities in health delivery systems?

3. What is the experience of minorities in the disability process?

4. What is the experience of minorities in the rehabilitation process?

The purpose of this paper is to draw attention to and increase awareness of the unique needs of minorities with disabilities in the area of physical health. We do this by making a conceptual link between minorities, physical health and disability. Then, we establish the need to empirically interrelate these factors for meaningful research and policy planning. First, we review the state of physical health of minorities in the U.S. This is followed by an exploration of available information about minorities with disabilities, current models of the disability process and its

* In Fall 1992, Dr. Leal wil become Coordinator, Reabilitation Counseling Program, California State University, Freso, CA, School of Education, Department of Counseling and Human Development.]

application to minorities. Then we briefly examine their experience in the state/federal vocational rehabilitation system. Recommendations are then presented.

Disability is not yet fully a part of the debate on the need for better health care for minorities, in particular minorities with disabilities. Instead, epidemiology studies the distributions of the states of health of human populations, focusing on pathology and ignoring disabilities, to the chagrin of the disability studies' field.

This paper centers on what are considered the four primary racial/ethnic minority groups in the U.S. which, for purposes of this report, will be termed "minorities." These minority groups include the following:

1. African Americans (i.e. Blacks) are the largest minority group in the U.S. and make up approximately 12 % of the population. Thirty-six percent of African Americans, compared to 23% whites, had not graduated from high school in 1987 (U.S. Department of Health and Human Services, 1991). In 1986, 31.1% of Blacks lived below the poverty level compared to 11% of Whites. One-third of Blacks live below the poverty level.

2. Hispanics (i.e. Latinos) are the second largest minority group in the U.S. and make up 8% of the general population. This complex, heterogeneous group made up of Mexican, Cuban, Puerto Rican and Central and South American origin people share a common language (Spanish) either as a first or second language. Hispanics are considered an ethnic group and also are classified primarily as White 90% of the time in racial categories. What characterizes this group in particular is its low educational attainment as well as its youth. Forty-nine percent of Hispanics over age 25 have not completed four years of high school. Further, the proportion of Hispanic children under 18 years of age living in poverty is significantly greater compared to non-Hispanics (47.7% compared to 38.3% respectively) (U.S. Department of Commerce, 1991). Based on limited data, Hispanics' health status is closer to that of Whites than other minority groups. However, because of classification problems (e.g. Hispanics are often lumped together with Whites), vital statistics data for Hispanics is inconsistent and in many cases unavailable.

3. Asian/Pacific Islanders are the fastest-growing minority population in the U.S. and make up about two percent of the population. Six major Asian American subgroups have been identified: Filipinos, Chinese, Japanese, Vietnamese, Asian Indians, and Koreans (Yu, 1991). Rapid growth is primarily due to large numbers of recent Southeast Asian immigrants. Data is scant regarding health risks and morbidity patterns of Asian-Americans subgroups. There are only a few epidemiologic surveys done in the West and most studies are done in Hawaii. Still unknown is the socioeconomic and demographic characteristics that affect health risk profiles of Asian Americans. Median family income is reportedly higher for this group compared to other minority groups and Whites. However, when subgroups differences are considered, the Vietnamese, for example have a very low average family income (Nickens, 1990).

4. Native Americans and Alaska natives are the smallest U.S. minority group and make up about one percent of the population. They have poverty rates similar to those of African Americans and Hispanics. Next to African Americans, they have the worst health status of the minority groups.

Three major health reports provide much of the information for this report.

1. The Report of the Secretary's Task Force on Black and Minority Health (1985) documents excess morbidity (i.e. illness) and mortality (i.e. death) for minority groups. This report focuses on six health problems which accounted for over 80 percent of deaths among minorities: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents, and infant mortality.

2. The Health Status of Minorities and Low-Income Groups (1991) is compiled by the Health Resources and Services Administration (HRSA), specifically the Division of Disadvantaged Assistance (DDA). This report, now published in a third edition, characterizes the lack of parity in health status as an inequity between the disadvantaged and advantaged elements of U.S. society. The disadvantaged were defined as "those who, by virtue of racial or ethnic heritage, economic status, or some other factor, do not have equity in access to the health care system." (HRSA, 1991)

3. Disability in America is a landmark publication in the field of disability. Its focus is on "prevention of potentially disabling condition from developing into disability and on minimizing the effects of such conditions on a person's productivity and quality of life.

Physical Health Status of Minorities

There is a somewhat bewildering phenomenon experienced by African Americans in the U.S. - bewildering because it is contrary to research evidence and, hence, expectation. After age 65, the gap in life expectancy between African Americans and Whites actually begins to narrow. This has been explained as the "survivor effect" (Waller, 1991). The "survivor effect" refers to the fact that in spite of the high probability that people of minority group origin will live a shorter life compared to non-minorities, if they do survive to age 65, they actually have ". . . lower death rates for many diseases than do Whites" (Waller, 1991, p. 85).

This hardiness, in spite of the odds does not significantly impact the persistent problem of excess deaths of Blacks (i.e. deaths over and above the rate for Whites). This situation is further intensified for minorities with the threat of the human immunodeficiency virus (HIV) and related acquired immunodeficiency syndrome (AIDS).

Health equity remains elusive in the U.S. and continues to raise serious questions about minorities' access to health care. Life expectancy has increased to 71 years for men and 78 years for women, yet data from 1985 and 1986 reveals that the life expectancy for Black men and women decreased by 0.3 years while that of Whites

increased by 0.3 years for the same period (Helzlsouer & Gordis, 1990).

The landmark 1985 Secretary's Report Black and Minority Health revealed these highlights about chronic disease:

1. The life expectancy of African Americans compared to Whites shows a gap of 5.6 years or an average of approximately 75 years for White men and women compared to approximately 69 years for African American men and women.

2. The physical conditions for which risks of death are highest for African Americans compared to Whites under age 45 are tuberculosis, hypertension and anemias. Further, end stage renal disease resulting from hypertension is more common among African Americans than Whites.

3. Death rates for heart disease are higher in African American men and women under age 70 than in Whites. Under age 45, death rates for heart disease is higher for both Native Americans and African American compared to Whites. Coronary heart disease and stroke is a primary cause of death in Hispanics and heart disease is the leading cause of death for all Asian/Pacific Islander American groups. Deaths due to stroke are higher for African American than Whites.

4. There is an 11 % excess incidence of cancer (e.g., prostrate cancer, cervical cancer, multiple myeloma) among Blacks compared to non-minority Americans, with Black men showing the largest increase in death due to cancer between 1972-77 and 1978-81, especially due to lung cancer (45% higher among Black males than non-minority males. Evidence supports the cause of differences in cancer death rates as social or environmental factors as opposed to genetic differences.

5. Excess cancer rates for Hispanics included the specific sites such as stomach, prostate, esophagus, pancreas and cervical cancers.

6. Incidence for cancer varies widely for Asians by subgroups. For example, Hawaiians demonstrate excess mortality for cancers of the breast and lung. Stomach cancer incidence is 2.5 times greater for Japanese males and 3.8 times greater for females than for non-minority males and females. Esophageal cancer is also 2.5 times higher in Japanese males compared to non-minority males.

7. Native Americans have the lowest rates of cancer incidence and death among all U.S. populations. Cancer is the third most common cause of death after accidents and heart disease for Native Americans.

8. Diabetes mellitus prevalence is 33 % higher in Blacks than in Whites, and is a major problem for Hispanics. Diabetes-related mortality rates are 2.3 times higher for Native Americans than the general population.

9. Heart disease is the leading cause of death for Asians and Pacific Islanders.

10. The excess death rate of Native Americans under age 45 is strikingly high at 43 % and is due to six causes: (a) unintentional injuries, (b) cirrhosis, (c) homicide, (d) suicide, (e) pneumonia, and (f) diabetes.

11. Asians have been reported to have a greater life expectancy than Whites. However, there are specific health problems among the various subgroups of this population. For example, Hawaiian studies reveal cancers of the stomach and lungs are very high compared to Whites. Further, the death rates for foreign-born Chinese, Japanese, and Filipinos are higher than for native-born Americans of these same subgroups.

The report, Health Status of Minorities and Low-Income Groups revealed that minority health has changed little from 1985 to the present. The exception is the increase in information about acquired immunodeficiency syndrome (AIDS) which was not available nor considered a crisis in 1985. The highlights of this report are as follows:

1. While more than three-fourths of all deaths in the U.S. are caused by chronic diseases, in almost all categories the rate is one-third to 2.8 times higher for African American than Whites.

2. Heart disease is approximately 40% higher for Blacks than Whites.

3. Death due to cerebrovascular diseases is still substantially higher for Blacks than Whites.

4. Cancer rates at all sites are higher for Blacks than for Whites.

5. Excess death for Blacks due to diabetes mellitus, chronic liver disease and cirrhosis has increased.

6. Hispanics show lower age-adjusted mortality rates from all causes combined and in particular from most chronic diseases with two exceptions: (a) diabetes mellitus, and (b) chronic liver disease and cirrhosis.

7. Mortality rates for Native Americans and Alaskan Natives are two to three times higher compared to Whites for diabetes mellitus, chronic liver disease/cirrhosis and tuberculosis.

8. Out of 117,781 AIDS cases reported in the U.S. in 1989, 56% were for Whites, 26% among African Americans and 15% among Hispanics. The risk of AIDS in Black and Hispanic men was almost three times that of White men.

9. Fifty-one percent of all female cases of AIDS were among Black women; 19% of female cases of AIDS were among Hispanic women.

10. It is estimated that out of 1.5 million Americans infected with human

immunodeficiency virus (HIV), 0.5% are White, 1.5% are African American and 1.5% are Hispanics.

11. The mortality rate from tuberculosis for Native Americans and Alaskan Natives is approximately four times the rate for the U.S. population in general.

12. Blacks have a 25 % lower incidence of acute conditions compared to Whites in all categories.

13. Hispanics are at or below the White rates for pneumonia.

14. The excess deaths of Blacks from pneumonia compared to Whites has significantly decreased.

15. The need for eye treatment among Black adults was found to be significantly higher than for Whites (Waller, p. 94).

16. Blacks suffer from uncorrected visual impairment more often than Whites. This may also be true for hearing impairment among Blacks compared to Whites.

17. Blacks visit physicians more for mandatory rather than elective care more often than Whites.

18. Blacks have been found to receive fewer preventive services than Whites.

19. Diabetes mellitus is more prevalent among Blacks compared to Whites.

20. Obesity is more prevalent among Black and Hispanic women compared to Whites.

Minorities with Disabilities

Disability

It is estimated that 35 million Americans have conditions of disabilities that interfere with their life activities. Minorities are disproportionately over-represented among this number (Pope & Tarlov, 1991). The meaning and concept of "disability" has undergone significant transition. Its traditional meaning was limited to a medical condition consistent with the medical model. Its meaning has expanded to include environmental, contextual factors as well as medical. Most recently, disability has been conceptualized as ". . . the expression of a physical or mental limitation in a social context - the gap between a person's capabilities and the demands of the environment. It is the interaction of their physical and mental limitations with social and environmental factors that determines whether they have a disability." (Pope &

Tarlov, 1991, p. 81).

According to Nagi, the severity of disability depends on the following: ". . . (a) the individual's definition of the situation and reaction, which at times compounds the limitations; (b) the definition of the situation by others and their reactions and expectations; and (c) characteristics of the environment and the degree to which it is free from, or encumbered with physical and sociocultural barriers" (Pope & Tarlov, 1991, p. 81-82).

Disability is the final end state, though not necessarily irreversible, of a process which starts with a physical or mental condition or pathology -- the first stage of the disabling process. The next stage of the process is impairment and refers to the losses caused by the disease (e.g., absence of a body part). This is followed by the functional limitation stage and refers to the manifestation of limited performance capability (e.g., inability to lift heavy objects). When the individual reaches the disability stage, a noticeable interval is evident between the physical limitations and the environmental demands.

The key to whether a physical health condition (e.g., chronic disease) becomes a disability depends on several risk factors. Biological factors such as physical health status, both prior to and following the onset of a chronic disease can have significant influence on the process. Environmental factors such as socioeconomic status can alter the course and/or serve as a point of intervention and prevention of disability. Educational status, related to socioeconomic status, also has a bearing on the disability process. "People with higher education have lower levels of disease and disabilty." (Pope & Tarlov, 1991, p. 93).

It becomes clear that disability risk factors which interact with the disabling process have significant implication for minorities who are already confronted with sociocultural barriers which interact with and, in part, place them at risk for chronic diseases and ultimately, at great risk for disability.

Disability Studies and Minorities

Until recently, incidence and prevalence of disability among minority groups was simply not reported in the disability literature. Little is known about the disability process experience of minorities. Wagener stated "...particularly in the field of disability and rehabilitation, this seeming insensitivity has been due not so much to prejudice but rather to a milder form of ethnocentrism that minimizes differences among persons." (Wagener & Winn, 1991, p. 1413).

Even in the landmark Disability in America study, minorities are given only passing mention. While there is an acknowledgement that "....disabilities are disproportionately represented among minorities, the elderly and lower socioeconomic populations..." (Pope & Tarlov, 1991, p. 1), minorities are not mentioned in the recommendations of the report. The report does, however, mention

the following facts regarding minorities:

1. The incidence of traumatic brain injury is greatest for non-White urban populations and lowest for White populations living in suburban and rural areas. (p. 12).

2. Blacks experience a higher prevalence of activity limitation than Whites - 16.3% for Blacks compared to 12.8% for Whites, when differences in age distribution are taken into account.

3. Blacks are likely to experience a greater degree of activity limitations so that the proportion unable to carry out major activities is substantially higher for Blacks (6.6%) than for Whites (3.5%); (p. 46).

4. Although life expectancy increased more for Blacks than Whites between 1970 and 1980, the expected number of activity-limited years also increased for Blacks (p. 64-65).

5. Fetal Alcohol Syndrome (FAS) rates among Blacks are as much as six times higher than those for Whites. For Native Americans, FAS rates are 40 times greater than for Whites.

Disability Rates of Minorities

Statistical evidence of disability prevalence among minorities, as stated earlier, is very limited. There is an indication that the rate of disability in the general population is increasing (Helzlsouer & Gordis, 1990). Further, there is an indication that the rate of disability in the minority population is increasing as well. Wright (1988) estimated that the percentage of ethnic minorities with disabilities would increase proportionately to between 20 and 50 million persons in the coming decade.

Bowe (1983) found that the disability rate of adults of working age in the U.S. who reported a disability limiting the amount or type of work they could do is 8.5%. He noted that of working age Blacks, just over 14% were disabled. He found that 8.4% of Hispanic adults reported a work disability. Bowe sketched the following profiles of working-age Blacks and Hispanics with disabilities. Blacks with disabilities were likely to be female, 42 years of age, tenth grade education, unmarried, not in the labor force, have had less than $3,000 income from all sources in 1983; Hispanics with disabilities were likely to be female, 40 years of age, ninth grade education, married, not in the labor force and have more than $3,500 in income from all sources in 1980 (p. 3).

More recent data reveals an increase in disability prevalence among minorities. LaPlante (1988) conducted a statistical analysis of the National Health Interview Survey for years 1983-1985.

Table 1

Prevalence of Work Limitation* due to Chronic Conditions by Race and Ethnicity

		Degree of work limitation			
		Limited in amount or kind of work activity		Unable to work	
Race	Total	Number	Percent	Number	Percent
White	120,555,000	6,234,000	5.2%	7,390,000	6.1%
Black	16,273,000	710,000	4.4%	1,676,000	10.3%
Hispanic	8,033,000	266,000	3.3%	480,000	6.0%
Asian or Pacific Islander	2,892,000	68,000	2.3%	94,000	3.3%
Native American	876,000	62,000	7.0%	91,000	10.4%

*Black Hispanic numbers were reported by LaPlante to have low reliability because of small numbers and are not included here.
Source: Ries, P., and Brown, S. Disability and health: Characteristics of persons by limitation of activity and assessed health status, United States, 1984-88. Advance data from vital and health statistics; DHHS Pub. No. (PHS) 91-1250, no. 297. Hyattsville, Maryland: National Center for Health Statistics.

Table 1 shows the percent of persons by race who reported on the National Health Interview Survey (NHIS) as being limited in work activity or unable to work due to chronic medical conditions. Combining those with limited work ability with those unable to work due to chronic medical conditions, we find that the rate of disability was 11.3% for Whites; 14.7% for Blacks; 9.3% for Hispanics; 5.6% for Asian/Pacific Islanders and 17.4% for Native Americans. These conditions included tuberculosis, neoplasms, diabetes, psychoses, multiple sclerosis, all heart conditions, and arthritis among several other conditions. Based on this percentage, it is conceivable that in 1989 as many as two million people of Hispanic origin persons were disabled during the period in which LaPlante conducted his analysis. However, during 1989 only approximately 17,000 people of Hispanic origin with disabilities were rehabilitated in state-federal vocational rehabilitation systems (Leal, 1992a).

Table 2
Persons Age 16 to 64 with a Work Disability by Race/Ethnicity

Race	Year	Total	Number with Work Disability	Percent of Total
White	1981	125,723,000	10,554,000	8.4%
	1988	132,992,000	10,544,000	7.9%
Black	1981	16,157,000	2,280,000	14.1%
	1988	18,299,000	2,512,000	13.7%
Hispanic	1981	8,324,000	702,000	8.4%
	1988	12,362,000	1,011,000	8.2%

Source: Bennefield, R. L. & McNeil, J. M. (July, 1989). Labor force status and other characteristics of persons with a work disability: 1981-1988. Current Population Reports, Special Studies Series P-23, No. 160. United States Department of Commerce, Bureau of the Census.

The most recent information on disability prevalence among minorities is provided by the Bureau of the Census. This table reveals that between 1981 and 1989, the self-reported disability rate for all groups decreased as follows: .5% for Whites; .4% for Blacks; and .2% for Hispanic origin people. Yet the disability rate for Whites is still lower than for either Blacks or Hispanics. In other words, there is an excess disability rate for minorities. The concept of excess disabilities, that is, disabilities over and above the rate for Whites, is an important concept to explore in future research and in planning for minorities with disabilities.

Linking Minorities, Physical Health and Disability

In the first descriptive study of its kind, Ries and Brown, using data from the National Health Interview Survey (NHIS) for the years 1984-1988 described the characteristics of persons in fair, poor, good or excellent health in terms of limitation of activity and by race. The NHIS is based upon self-report data only. This study was based on an overall population sample of approximately 504,000. Overall, they showed that 82.5% of the U.S. population reported they were not limited in activity and were in good to excellent health. However, of the remaining 17.5 percent, 6.1% reported they were limited both in activity and in health. Table 3 shows the average annual percent distribution of Blacks, compared to Whites by limitation of activity and health status. Overall, a larger proportion of Blacks compared to Whites reported that they were both limited in activity and in fair or poor health.

Table 3
Average Annual Percent Distribution of Blacks Compared to Whites by Limitation of Activity Due to Chronic Conditions and Health Status

	Blacks	Whites
Limited in activity in fair or poor health	8.7%	5.8%
Limited in activity in good to excellent health	5.8%	8.0%
Not limited in activity in fair or poor health	6.7%	3.7%
Not limited in activity in good to excellent health	78.8%	82.4%

Source: U.S. Department of Health and Human Services Advance Data, "Disability and health: Characteristics of persons by limitation of activity and assessed health status, United States, 1984-88 by Peter Ries and Scott Brown.

Minorities with Disabilities: The Vocational Rehabilitation System

Another source of untapped data on minority people with disabilities is collected by the Department of Education, Rehabilitation Services Administration (RSA). This data can provide information about access and utilization of rehabilitation services by minorities and about their health status. In a recently completed study by Leal (1992b), characteristics of minorities' experience in state-federal vocational rehabilitation agencies throughout the nation were described. Table 4 shows the number of rehabilitants for FY 1989 by race and by Hispanic origin. Of a total of 213,842 persons rehabilitated in 1989, 80% were White, 17.5% were Black, .08% were of Hispanic origin, .013 were Asian/Pacific Islander and .005 were Native American.

Table 4

Rehabilitated Persons in FY 1989 by Race and Hispanic Origin

Race	Total	Hispanic Origin	Non-Hispanic Origin
White	172,292	16,146	156,146
Black	37,561	661	36,900
American Indian/ Alaskan Native	1,208	60	1,148
Asian/Pacific Islander	2,781	562	2,219
Total	213,842	17,429	196,413

Source: United States Department of Education, Rehabilitation Services Administration, provided by Senior Statistician Larry Mars in July of 1991, for fiscal year 1989.

Table 5 shows the major or primary disability of rehabilitants in U.S. state-federal vocational rehabilitation systems for FY 1989. The primary disability reported by state agencies in the aggregate for the nation by race is as follows: Whites (orthopedic impairments, 22.7%); Blacks (mental retardation, 21.0%); American Indian/Alaskan Native (substance abuse, 20.7%); Asian/Pacific Islanders(mental illness, 23.9%); and, Hispanics(orthopedic impairments, 24.3%).

Table 5
Major Disability Summary of Persons Rehabilitated in State-Federal Vocational Rehabilitation System in Fiscal Year 1989 By Race and Ethnicity

Disability	Number and Column Percent				
	White	Black	American Indian/ Alaskan Native	Asian/ Pacific Islander	Hispanic
Orthopedic Impairments	36,319 (22.7%)	4,910 (13.2%)	238 (19.5%)	479 (21.4%)	479 (24.3%)

Mental Illness	25,860 (16.1%)	6,344 (17.0%)	143 (11.7%)	536 (23.9%)	7,203 (15.9%)
Mental Retardation	19,637 (12.3%)	7,847 (21.1%)	145 (11.9%)	281 (12.5%)	3,825 (8.5%)
Substance Abuse	15,988 (10.0%)	5,353 (14.4%)	253 (20.7%)	92 (4.1%)	5,756 (12.7%)
Hearing Impairments	16,325 (10.2%)	2,104 (5.7%)	68 (5.6%)	260 (11.6%)	2,586 (5.7%)
Visual Impairments	13,486 (8.4%)	3,264 (8.8%)	122 (10.0%)	196 (8.7%)	4,947 (10.9%)
Learning Disabilities	8,597 (5.4%)	1,911 (5.1%)	89 (7.3%)	113 (5.0%)	2,690 (6.0%)
Heart/Circulatory	4,115 (2.6%)	639 (1.7%)	19 (1.6%)	44 (2.0%)	1,025 (2.3%)
Absence of Limbs	2,800 (1.7%)	691 (1.9%)	16 (1.3%)	42 (1.9%)	703 (1.5%)
Digestive Disorders	2,544 (1.6%)	727 (2.0%)	23 (1.9%)	19 (0.8%)	659 (1.5%)
Genito-Urinary	1,905 (1.2%)	603 (1.6%)	15 (1.2%)	21 (0.9%)	537 (1.2%)
Respiratory Conditions	684 (0.4%)	141 (0.4%)	5 (0.4%)	23 (1.0%)	217 (0.5%)
All Other Disabilities	11,942 (7.5%)	2,679 (7.2%)	85 (7.0%)	137 (6.1%)	4,052 (9.0%)
Total	160,202	37,213	1,221	2,243	45,182

Access to Health Care Delivery Systems and Services

The racial/ethnic differential in morbidity and mortality rates, as we have seen, depends on several factors. Primary among them is access to health care. According to Helzlsouer and Gordis (1990), susceptibility to disease, risk of exposure, response to disease treatment, and access to health care delivery systems are primarily responsible for the differential.

The startling implication of the 1985 Report of the Secretary's Task Force on Black and Minority Health is that all six leading causes of death were preventable. The nature of an individual's initial encounter with a health delivery system, including the vocational rehabilitation system, has a dramatic impact on whether he/she will continue the process. In order to prevent disease and disability, an encounter with a health system is necessary. The Health Status of Minorities report makes the following important points regarding barriers to access of medical care:

1. Blacks have a low rate of physician contact compared to Whites. This includes Blacks who are both above and below the poverty line.

2. The indicators of lowered preventive care practices of minorities is reflected in lower rates of vaccination, prenatal care, and dental services.

3. The high cost of medical care is prohibitive to minorities who are overrepresented below the poverty line.

4. Lack of insurance coverage is common among lower socioeconomic and unemployed minorities.

5. Poorly located service sites, lack of minority providers of care, and lack of services provided in the first language of clients act as barriers to health care.

Conclusion and Recommendations

Disability as a health and social issue gets minimal attention from the epidemiological community (Nagi, 1976), and the disability community itself neglects minorities in its policy planning. There is sufficient evidence that minorities are particularly at risk to develop both acute and chronic medical illness which can progress to disability. There is also mounting evidence that medical services as well as disability/rehabilitation services have been underutilized by minorities. The picture of the physical health status of minorities in the U.S. and its direct relationship to the disabling process is an overwhelmingly bleak one. This information confirms the need for a special public health policy on the unique needs of minority people with disabilities. Although we know of the widespread social and medical problems facing minority groups in this country, we have not conceptually nor empirically linked disability and rehabilitation with physical health status. This particular area must be the focus of research and policy planning if we are to intervene effectively in the disabling process of minorities. With this in mind, the following recommendations are proposed:

1. Disability must be understood and accepted as a health issue with a special focus on minorities. It must be considered a general health issue by both the health and disability policy planners and researchers and not only an afterthought.

2. There is a need for improved collection of information on the incidence and prevalence of disability among minorities as well as research into the most effective points of intervention in the disabling process.

3. Utilization of existing databases heretofore untapped must be improved and used as a basis for further research in order to learn about physical health needs of consumers, (e..g., Rehabilitation Services Administration). Further, it is strongly recommended that the Rehabilitation Services Administration more fully utilize data regarding physical health needs of minorities by further exploring Restoration Code 16 (i.e. provision of physical health services and other restorative services).

4. Fund additional research on the physical health status of people of minority group origin, in particular Blacks, Native Americans, Asians and Pacific Islanders and Hispanics. There is a need to generate data in this area and to standardize categories. In particular, there is a great need to identify specific subgroup experiences.

5. The aggressive recruitment and inclusion of minority researchers and educators in the field of health, disability and vocational rehabilitation is strongly encouraged. Funding of research projects to minorities as principal investigators is paramount.

6. It is necessary that the gap be bridged between the minority communities and government agencies who are charged with the provision of health related services to the community, including the Rehabilitation Services Administration, be bridged.

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Reaction to Minorities, Physical Health and Disability

William A. Murrain, J.D.
Program Specialist
Centers for Disease Control
Atlanta, GA

I wish to draw your attention to what I consider are two of the most salient points of Dr. Leal's presentation:

1. Survivor Effect:

Dr. Leal outlined at some length in her paper the concept of "The Survivor Effect", which essentially states that in spite of the high probability that people of color will live a shorter life, as compared to non-minorities, and that during their life span they will experience poor health and related disabilities made worse by their limited care resources, they, in fact, do survive and actually have lower death rates for many diseases than do non-minorities. The fact is, the inequities which confront ethnic-minorities will also function to deny them the opportunity to demonstrate this hardiness of survivability.

We should note that among the factors which operate to decrease the "survivability effect" throughout ethnic communities is the absolutely incredible fact that the six leading causes of mortality or morbidity within the African American and to some extent in other ethnic minority communities are behavioral induced. Consequently, if these illnesses are behavioral induced, they are also avoidable and preventable. The causes are:

- Cancer
- Cardiovascular disease/stroke
- Diabetes
- Homicide & Accident
- Infant mortality
- HIV/AIDS

Does this imply a death wish or simply that there are other operative inhibiting factors?

In her presentation of the issue of the physical health of ethnic populations, Dr. Leal pointed out that African Americans visit their physicians more often for mandatory rather than elective care and that they receive fewer preventive services than Whites.

A natural consequence is that the quality of their physical health proportionately decreases as their susceptibility to the onset of related disabilities increases. If access and utilization of medical/healthcare services are reflected by the differences in mortality rates, then I pose two questions for you to consider:

- What does this premise imply? and
- What is our call to action?

Data:

The odds against the "survivability factor" operating to the benefit of the disenfranchised and underserved ethnic populations are further exacerbated by the absolute lack of credible and reliable data on the health status of this nation's ethnic minorities.

Formulation of policy throughout every sector of this nation is data driven. In the absence of credible and reliable data, a concomitant condition exists of an absence of focused policy resulting in the development and implementation of unreliable and thus unsubstantiated policy. Should not ethnic minorities and their committed allies immerse themselves in the effort to collect, aggregate and analyze relevant data which would then serve as the basis from which meaningful policy is developed and implemented? How, in the absence of reliable and credible data do we develop and implement policy if we are unable to assess the true extent of actual, primary, secondary and preventable disabilities throughout the minority communities? We have relied on extrapolated data for far too long. The Centers for Disease Control and the American Council on Epidemiology have recognized this deficit in their data collection efforts and are acting to correct it.

African American, Latinos, Native American, Asian and Pacific Islanders and other ethnic minority populations constitute a larger proportion of the populations who experience limited and poor healthcare. If the premise holds that persons with bad or poor health usually have some disability, then I submit that persons who are disabled are often, but not always, in bad health. I second Dr. Leal's recommendation that we have an urgent and pressing need for an informed public health policy; a policy which is founded on a truly representative, aggregated and analyzed database. This effort can only be achieved with the creation, solicitation, and involvement of:

* Minority participation as:

- Epidemiologists
- Biostatisticians
- Committed community based organizations
- Health Policy formulators and implementers

* Sensitive members/professionals of both minority and majority health care professionals.

Finally, I strongly recommend that the National Council on Disability create a Minority Advisory Panel. The Panel would be charged to assess the extent and impact of primary and secondary disabilities throughout the various ethnic communities.

Reaction to Minorities, Physical Health and Disability

Janet I. Foster, Program Director
New York State Department of Health
Albany , NY

Dr. Leal reports in her presentation that gender, socio-economic circumstances, age and race are determinants of one's access to health care and therefore the overall quality of one's life . . . and I agree.

Further, Dr. Leal's supportive references suggest that although the life expectancy for Blacks is six years shorter than that of Whites, Blacks demonstrate a hardiness that shortens that gap in persons 65 years of age and over.

Longevity experienced in good health with no disabling occurrences is my wish for everyone. However, of major interest to me is the quality, availability and frequency with which young adults receive medical treatment.

Once incarcerated or impregnated, sometimes our children receive adequate health care. For infants and toddlers, there are free well baby clinics. But for young adults, there is a void in treatment and access to preventive health care. Research supports the notion that young Black men between the ages of 16-24 years are at high risk for physical accidents and rarely invest in preventive health treatment. Empirical evidence suggests that for many young Black men, their next visit to a doctor after their last infant DPT, polio or smallpox vaccination is a life saving emergency room visit!

I am concerned about that lapse in treatment! Young people are frequently engaged in adventurous, risky and body banging physical activities (basketball, football, wrestling, skiing and diving) during the important developmental years of 12-24. The incidence of athletic related injuries is greatest during this age range. Our insurance premiums indicate that male drivers under 25 years old are most likely to experience an automobile accident. Automobiles and athletic activities are the most frequently reported contributing/causal factors leading to traumatic brain injury for all young men 16-30 years of age.

The pandemic of HIV/AIDS threatens all of our lives but most especially those persons 12-30 years old. An awakening sexuality, freedom of expression and a sense

of immortality has allowed some young adults to engage in one of the most life threatening experiences of this decade . . . . . unprotected sex. Among college aged individuals, the rate of HIV infection is one person for every 250 persons. That might mean that of the 2,000 full time students registered here at Jackson State University, eight are probably HIV positive. HIV/AIDS is an equal opportunity disease. It impacts males as well as females, old and young, African American or White, rich or poor and gay or heterosexual.

As Carl Boyd, this morning's guest speaker suggests, our approach to a problem helps to determine its outcome. I'd like to recommend that our long range health goals include educating our youth about the benefits of a wholesome lifestyle. Establishing positive patterns of behavior that affect mental, physical, sexual and emotional well being should be a portion of early childhood education. These patterns of behavior could then be naturally and comfortably taken into one's old age. Disabilities deriving from over-eating, hypertension, smoking, poor nutrition and substance abuse might be eliminated.

Public policy regarding minorities with disabilities is to my knowledge non-existent. It will be up to us, the minority community to determine, develop and financially support the inherent hardiness that Dr. Leal spoke of early in her paper. I am acquainted with a group of concerned citizens who have named themselves the Living Well Commission. Every member of the Living Well Commission is either infected or affected by/with HIV. Every member is also determined to assist all human beings in the healthy pursuit of long life. Instead of waiting for death, they have decided to live the rest of their lives well.

Thank you for your kind attention.

SUBSTANCE ABUSE

Substance Abuse and Disabilities Among Minorities

James G. Brown, Ph.D.
Florida Department of Labor and Employment Security
Division of Vocational Rehabilitation
Tallahassee, FL

Introduction

Prevalence and Incidence of Disabilities

A 1991 National Institute on Disability and Rehabilitation Research (NIDRR) national conference theme was "Future Frontiers in the Employment of Minority Persons with Disabilities". At that conference, William H. Graves, Director of NIDRR presented statistics which showed that over the past 25 years there has been a 70% increase in the prevalence of severe disabilities in the American population. Much of the increase was due to the lack of preventive medical care in the minority community, particularly the minority community with disabilities. The root causes are sociological and political factors which result in economic impoverishment and the inability to afford basic medical care. The situation is getting worse (i.e., 33 million Americans are currently disabled, and this number will probably increase to 41 million by the year 2000 and 47 million by 2010). A large percentage of these growing numbers of disabled persons will be members of minority groups.

Alcohol and Substance Abuse Coexisting with other Disabilities

Although the scope of the alcohol and substance abuse problem coexisting with other disabilities is not well known, it is recognized that alcohol and substance abuse is a problem in many persons who have physical and/or mental disabilities (Anderson,1980; Boros, 1980; Greer, 1986). The Rehabilitation Services Administration (RSA) reported that approximately fiive percent of the people served by state/federal vocational rehabilitation programs are multidisabled alcoholics (Hindman, 1990). Some researchers estimated the prevalence of alcohol and substance abuse for the persons with physical disabilities as ranging from 10% to 60%, compared to 8% to 10% in the general population (Western Center for Drug Free Schools and Communities, 1990). Thurer and Rogers (1984) found that 53% of a sample of clients with physical disabilities rated help with alcohol or drug use as a substantial or great need. Other researchers have found high incidence of alcohol abuse in traumatically brain injured persons pre- and post-injury, (Kreutzer, 1989; Field, 1976; Rimel and

Jane, 1983).

Substance abuse also frequently coexist with mental disorders, (Bell, R., Schwab, J., Lehman, R., Traven, N., & Warheit, G., 1977; Weissman, M., Meyers,J., & Harding, P., 1980; Harmatz, J., Shader, R., & Salzman, C, 1972). Part of the reason may be that persons with mental disabilities, like persons with physical disabilities, are under a great deal of stress which can lead to alcohol and drug abuse in many instances. For some, the continuing use of alcohol and drugs is associated with the inability to afford residential alcohol and drug treatment. For others, substance abuse may be the result of medical treatment (e.g., pain killers for disabled persons suffering chronic pain). Others become addicted because service providers do not recognize the early warning signs of abuse and thus the problem escalates into addiction, or the service provider underestimates the risk of addiction with the misguided belief that the disabled person deserves a drink or chemical "high" because of the suffering the disability has caused.

McCrone (1982) estimated that substance abuse among people who are deaf as approximately 73,000 alcoholics, 8,500 narcotic addicts, 14,700 cocaine/crack users, and 110,000 marijuana users. Steitler(1984) estimated that one million people who are deaf in the U.S. need professional help for substance abuse. Buss and Cramer (1989) cited results from a survey by the Office for Persons with Disabilities and for Alcohol and Other Drug Abuse in Wisconsin which suggested that there is a notable substance abuse problem within the visually impaired community.

The following sections will focus on African-Americans, Hispanics, Native Americans, and Asian-Americans and how substance abuse affects minorities who have disablilities. More information was available on African-Americans, perhaps because currently this is the largest minority group in the U.S. There is also a growing body of literature on the Hispanic population perhaps because this is the fastest growing minority population in America. However, there was a notable lack of information on Asian-Americans with disabilities. Given these constraints, I tried to give equal attention and concern to each group. (Note: I am of African-American descent and apologize for any errors in the interpretation of data or insensitive description of issues relating to the other minority groups. I have not had sufficient personal or clinical experience with these individuals, therefore I might not be as sensitive or insightful regarding the dynamics of other people and their cultures.)

African-Americans

African-Americans face many problems. The root of many of these problems is primarily economic. Many persons in the African American community believe that the lack of African American owned businesses is a major barrier to a higher standard of living for African-Americans (National Urban League, 1991; Holliday, 1990). The result is a high incidence of poverty.

Poverty contributes to the increased incidence of disability in the African-American population. According to the 1980 Census, 12% of the U.S. population is

African-American. Of this 12%, 14.1% of Black adults (14.3% males; 14.0% females) have some sort of disability compared to 8.4% of the white population (Wright, 1988). Briggs (Cited in Wright, 1988) reported a 60%-90% unemployment rate among African Americans with disabilities. The unemployment rate among African Americans in the U.S. population was 12.4% compared to 6% among Whites (Florida Labor Market Information, April, 1992).

Substance abuse in the U.S. has reached epidemic proportions according to the National Household Survey on Drug Abuse: Population Estimates 1991; 7.3 million Americans abuse alcohol; 37,530,000 have used crack cocaine at least once, 24,784,000 have used prescription drugs, 66,100,000 have used marijuana, and 681,000 have used heroin. In the African-American community, the prevalence of drug and alcohol abuse is also alarming. Approximately 7,678,000 drank alcohol in the past month; 987,000 have used crack cocaine at least once, 403,000 have used prescription drugs, 8,242,000 have used marijuana, and 101,000 have used heroin.

The most recent challenge is the threat of Human Immunodeficiency Virus (HIV) infection and transmission. The use of crack cocaine is rampant in sections of the African American community, and is associated with HIV infection because of reckless involvement in unsafe sex triggered by addiction to this drug. Heterosexually transmitted HIV infection is the fastest growing infection route. Twelve percent (12%) of African Americans with Acquired Immune Deficiency Syndrome (AIDS) are exposed via heterosexual sex (Center for Disease Control; February, 1992). The percentage (53.3%) of babies born with the HIV virus that are African-American is staggering. According to the Center for Disease Control (CDC), 28.8% of adult and adolescent persons with AIDS are African American (CDC, 1992). The emotional strain this situation places on parents, siblings, and families in general will likely produce an increase in mental health disabilities in the African American community.

Disabilities associated with substance abuse also appear to be more challenging to rehabilitate. First, the general population has a negative stereotype of substance abusing persons. It is viewed by many to be a moral weakness that result in logical consequences (i.e., punishment). Consequently, many rehabilitation counselors may not provide the attention to this population normally afforded other disability groups. The situation is compounded when the substance abusing person is African-American. Another reason for the difficulty in rehabilitating the substance abusing African-American is the related barriers or constraints that often accompany and coexist within the client group environment. For example, these individuals are often found to have few if any supportive individuals in their family to advocate for them, a factor strongly associated with successful rehabilitation (Belgrave & Walker, 1991). Other barriers include the lack of transportation, another critical factor in successful rehabilitation, (Belgrave & Walker, 1991); a greater sense of hopelessness that the rehabilitation process will work; a history of failure and chronic emotional distress contributing to learned helplessness; more severe addiction due to the lack of affordable drug rehabilitation treatment; an insufficient number of culturally sensitive drug rehabilitation services resulting in fewer effective services; and an exposure to

home and neighborhood environments in which drugs and alcohol are more accessible and acceptable.

I believe that the strategy for addressing the epidemic abuse of alcohol and drugs should emphasize prevention first, treatment second, and lastly interdiction. To accomplish these strategies, I recommend the following:

Legislative Recommendations

- Lobby for the legislation of federal, state and local tax funding formulas which designate that tax revenues be spent for prevention, treatment, and interdiction, respectively.

- Require set-asides for: (a) minority drug treatment providers who are racially, ethnically or culturally members of the group being served, and b) programs that may be predominately white but have treatment staff who are members of the target clientele. When employed by predominantly white programs, it is important that these treatment staff have decision-making roles in the programs.

- Lobby for legislation and funding to develop and enhance African American business (e.g. implementation of community reinvestment laws which require banks insured by the federal government to re-invest in African American communities). Re-investment initiatives should not only provide opportunities for buying homes, but should increasingly provide opportunities for developing and enhancing African American businesses.

- Increase funding for minority enterprise offices to encourage more minority vendors to seek business ventures with local and state government.

- Include grass root and community based organizations in federal grants initiatives which address the problem of alcohol and substance abuse to ensure that these programs are funded at significantly higher levels. Because many of these providers are considered "paraprofessional" or "lay" treatment providers should not be a reason to find them ineligible for funding if they demonstrate an ability to successfully perform.

- Ban the placement of bill boards in African American communities encouraging the use of cigarettes and alcohol.

- Ban television advertisements encouraging the consumption of beer.

- Lobby for legislation to implement national health insurance programs for all American citizens. This health insurance program should cover a significant percentage of the cost of drug treatment services.

- Institute a ceiling amount per insured, and monitor the cost of drug treatment services covered by the national health insurance program.

- Require pregnant mothers who are disabled by addiction to participate in drug treatment programs. Do not bring legal sanctions against them for delivering a baby with drugs in its system. Require monitoring of the babies' progress by social service agencies e.g. Florida's Health and Rehabilitative Services (HRS). Treat addiction as an illness not a crime.

Hispanics

Hispanics are the fastest growing and youngest minority group in the U.S. today. There are approximately 15-20 million Hispanics representing 9% of the U.S. population (44% are under the age of 18). This figure does not include the estimated 6 million undocumented Hispanic aliens who are predominantly Mexican (Lawson & Lawson, 1989). These individuals are of diverse cultural backgrounds but share the Spanish language. Hispanics in the U.S. are made up primarily of Mexican-Americans, Puerto Ricans, Cubans, and Central and South Americans. This diversity often creates additional problems in providing services.

A large number of Hispanics live in poverty. Approximately 22% live below the poverty index level compared to about 11% for non-Hispanics (U.S. Bureau of the Census, 1980). Hispanics face poverty related problems similar to African-Americans and other minority groups (e.g., lower educational levels, higher than average birth rates, poor health care, and higher incidence of alcoholism and substance abuse).

Hispanics also have a high rate of unemployment. Hispanic men have a rate of unemployment one-third higher than the national average (Lawson & Lawson, 1989). Chronic unemployment is a risk factor for alcohol and substance abuse. Additionally, individuals who are chronically unemployed and inadequately educated, often find jobs that are physically demanding and/or dangerous (e.g., heavy lifting, working around dangerous machinery, etc.). Therefore, the probability that these individuals will have higher rates of physical injury and disability is greater than individuals not working in these occupations.

Lawson and Lawson (1989) cited research that Hispanic families are three times more likely to experience alcohol related difficulties than families in the general non-Hispanic population. Many economically disadvantaged individuals try to escape or cope with the distresses of poverty by numbing their emotional and physical pain through the use of alcohol and drugs.

The pattern of substance abuse in the Hispanic population appears to be similar to the pattern seen in the mainstream U.S. population (i.e., the most often abused substance is alcohol, followed by marijuana, and cocaine and heroin). According to some researchers (Desmond & Maddox, 1984), Mexican- Americans

maybe second only to African-Americans in the abuse of heroin. It is also alarming that some researchers (Bell & Chambers, 1970) found that 56% of the Hispanics studied were under the age of 18 when they began to use heroin. Still other researchers (Padilla, Padilla, Morales, Olmeda, & Ramires, 1979) found a higher than average use of inhalants (e.g., model glue).

Not only does substance abuse, particularly alcohol abuse, contribute to disability, but intravenous drug use is a primary mode of transmission of the AIDS virus. Data reported on Hispanic heroin users suggest that they are at high risk for the spread of AIDS. The CDC HIV/AIDS Surveillance Report (March, 1992) indicated that 16.2% of adults and adolescents with AIDS in the U.S. are Hispanic, and 24.6% of pediatric cases are Hispanic. Additionally, because this population has a higher than national average use of inhalants, there is a greater potential for increased incidence of organic brain disorders (e.g., organic personality disorders, dementia, and learning disabilities).

Because the use of alcohol in the Hispanic community appears to be culturally acceptable, the incidence and prevalence associated with its use will probably continue to rise. Drinking is seen as an acceptable behavior by many in the Hispanic community, as it is in the mainstream American community. But in the Hispanic community, the cultural concept of "machismo" may encourage drinking beyond acceptable norms, particularly for teenage Hispanic males. It is important to note that traditionally, machismo has a strong positive connotation of the Hispanic man who takes care of his family, and carries himself in a respectful and dignified manner (Rivera & Cespedes, 1983). However, the "Americanization" of this concept has a decidedly negative connotation. Hispanic teenagers, in their acculturation process, may be influenced more by the "American" version of machismo. In addition, Hispanic immigrants have the added stress of learning to cope in a "strange" and often more permissive society. Consequently, they are likely to experience "culture shock". Stressors associated with culture shock contribute to substance use and abuse. For example, Hispanic teenagers change their values and belief systems faster than their parents. These changes occur with dating habits, dress codes, and in learning the English language. As a result, family tensions are created generating feelings of guilt, anger, alienation from the family, and severe parent-child conflicts. Such changes and conflicts tend to separate teenagers from their family. Peers are then sought for guidance as to what is appropriate behavior. Alcohol and drug use too often are the answers given.

Legislative Recommendations

Recommendations suggested earlier for African-Americans apply to Hispanics, Native Americans, and Asian-Americans. In addition, minorities who speak English as a second language should be provided the necessary interpreter services and providers who speak their native language to make services accessible.

Native Americans

Native American populations are made up of Indians, Eskimos, and Aleuts (Brod, 1975). According to the 1980 Census, there were approximately 1.4 million persons in the U.S. who identify themselves as Native Americans. This represents less than one percent of the total population. There are over 500 federally recognized tribes in the United States, and the list is growing as tribes which have not been recognized are petitioning for such recognition (Joe, 1991).

Like the African-American and Hispanic groups, but perhaps even more so, the Native American community is overrepresented on the "at risk" index. Jerry Lang, a Native American, and Senior Human Services Program Specialist for the Florida American Indian Rehabilitation Program, Florida Division of Vocational Rehabilitation, reported that the proportion of Native Americans and their families living below the poverty level is considerably higher than that of the general population (Native American Rehabilitation Program Annual Report, 1991). The median income level, he wrote, is below the nation as a whole. The proportion of families headed by a female exceeds the national average. The educational attainments of Native Americans remains considerably below the national level. Native Americans are not as likely to participate in the labor force as Non-Native Americans because often they do not identify with mainstream American values, ideas, and beliefs. The Native American population (like the Hispanic population) is considerably younger than the general population. Their median age is 22.9 years compared to 30.0 years for the majority population.

The Indian Health Service, a subdivision of the U.S. Public Health Service, many tribal leaders, and others, consider alcohol addiction in the Native American community to be a major health problem (Brod, 1975). Data reported in the National Institute of Mental Health publication indicated that the alcoholism death rates for Native Americans ranged from 4.3 to 5.5 times the U.S. rate for all races, and is increasing faster than the general U.S. rate (Brod, 1975).

Data on health consequences of alcohol abuse further depicts and highlights the impact of alcohol abuse in the Native American community.

- Four of the 10 leading causes of death for American Indians and Alaska Natives are alcohol related. The four leading causes are: disease of the heart, accidents, malignant neoplasms, and cerebrovascular disease;

- Chronic liver disease and cirrhosis is one of the top causes of death; and,

- At least 80% of homicides, suicides, and motor vehicle accidents in the Native American population are alcohol related (Alcohol Health & Research World, 1989).

Other facts and figures on Native American alcohol and drug use are equally alarming. Young Native American females use drugs at the same rate as males (Beauvais, Oettling, & Edwards, 1985). Fetal alcohol syndrome is 33 times higher among Native Americans than in Whites (Chavez, Cordero, & Becerra, 1989). Native American youth are consistently reported to have the highest prevalence rates for inhalants (an estimated 17 to 22 percent range). These ranges are twice as high than ranges reported for non Native-American youth. (May, 1986). Aggravating the situation of the Native American is the "catch 22" of acculturation and deculturation (Brod, 1975). Acculturation, as discussed with the Hispanic person, places demands on the Native American to assimilate into and identify with the values and beliefs of the dominant culture. The failure to accomplish this often leaves the Native American with lowered self-esteem and feelings of alienation. Lowered self-esteem and feelings of alienation contribute to feelings of discouragement and an array of other dysfunctional behaviors and conditions (e.g., substance abuse, chronic unemployment, disability). Deculturation is simply defined as the loss or devaluation of ones' historical traditions. Historical traditions provides the techniques and solutions that have worked for members of a culture in achieving those values that all cultures acknowledge, e.g., achievement, autonomy, and responsibility (Brod, 1975). When this devaluation occurs, dysfunctional behaviors increase. This has happened in the Native American culture bringing about a state of anomie, where the new values are not working for them and the traditional Native values have been rejected by the dominant society as "primitive" or are not considered to be relevant to living in the "mainstream". The acculturation/deculturation issue is particularly important in understanding the predicament of the Native American. For example, the Native American culture is far less competitive than middle class America. The philosophy of "win once, then let others win" is emphasized in the Native American culture.

Some researchers have reported that there is a strong genetic predisposition for alcoholism among Native Americans (Wolff, cited in Brod, 1975; Fenna, et al, 1971). Other researchers point to a cultural acceptance of large quantity and frequency of alcohol consumption as a reason for the high incidence of alcoholism (Brod, 1975). The Native American cultural tradition of ceremonial intoxication as well as the seeking of spirituality through altered states of mind achieved by fasting, meditation, and/or intoxication contributes to the cultural acceptability of drunkenness (Brod, 1975). Researchers also point to the social nature of alcohol consumption among Native Americans (Westermeyer, 1972; Berreman, 1956; Kunitz, 1971). Drinking in social settings occur because of the strong peer pressure. Group solidarity is said to be maintained in social drinking settings. Social drinking gives Native Americans a sense of "Indianness", that is, a form of defiance highlighting that Indians are different from the white man. Psychological explanations are that alcohol is consumed as a stress reducing activity (Brod, 1975).

Legislative Recommendations

- Support the National Congress of American Indians' recommendation to require that the entire 1% Title I allocation be spent for Section 130

VR programs. Currently, less than 25% of the allocation is being spent on VR programs for Native Americans.

- o Establish Research and Training Centers where the mission will be to 1) generate research information on health and cultural issues related to Native Americans and 2) develop technical assistance and training initiatives and activities to support service provision.

- o Continued funding of Research and Training Centers focusing on vocational rehabilitation issues relevant to serving Native American Indians.

- o Include Native American VR clients in discussions concerning the development of skills and expertise in tribal language, music, arts and crafts, etc. This would encourage the utilization of the strengths of traditional culture thus encouraging more self-determination and creating empowerment opportunities.

Asian-Americans

While the second smallest minority group in the U.S., Asian-Americans are probably the second fastest growing minority population in the U.S. Currently, four million Asian-Americans reside in the U.S. The earliest Asian immigrants to this country were the Chinese and Japanese, followed by other groups, such as the Koreans. The Vietnam War brought Laotians, Vietnamese, and Cambodians to the U.S. (Spicer, 1989). From 1980 to 1988, the Asian/Pacific population grew at an average rate of 6.6% per year, doubling past national Asian/Pacific population counts. Currently, the Asian/Pacific community is comprised of 28 ethnic groups with diverse cultures and languages. The 10 largest groups are: Cambodians, Chinese, Japanese, Korean, Filipino, Laotian, Thai, Tongan, Samoan, and Vietnamese (Woo, 1990).

Of all of the minority populations addressed in this paper, I had the most problems finding incidence and prevalence data on disabilities among Asian-Americans with or without coexisting alcohol and/or substance abuse. One reason is a scarcity of base rate data available on Asian-Americans with disabilities (Chan, 1976; Woo, 1990). The lack of statistical data on disability rates of Asian-Americans may be that Asian-Americans tend not to acknowledge the existence of disabled persons in their community (Woo, 1990). Many Asian-Americans, especially the Chinese, frequently perceive the handicapped person as an unsound and incomplete person who has been cursed for a sin committed by his or her ancestors and/or himself.

Parron (1990) identified the following at risk groups within the Asian-American population for mental health disabilities:

1) Indochinese refugees;

2) Asian wives of American servicemen;
3) recent immigrants, especially the elderly and children;
4) persons in areas undergoing rapid cultural change (e.g., parts of Hawaii, Samoa, Micronesia, Guam, and other Trust Territories); and,
5) Individuals with multiple problems (e.g., physical and developmental disabilities concurrent with specific mental health care needs).

While demographic data was not reported, Parron(1990) asserted that Asian-Americans are victims of economic, social, and political inequities as are other minority groups. She contends that Asian-Americans are victims of poverty, high rates of unemployment, inadequate health care, alienation, and powerlessness, and are also affected by acculturation issues. Based on data on Asian-Americans living in California and particularly in Los Angeles, Woo (1990) reported that 12% of Asian-Americans live below the poverty level. This is contrary to the belief that the Asian-Pacific American community is well educated and well off economically.

Cultural values appear to have both positive and negative affects on the occurrence and treatment of persons with disabilities in the Asian-American community. The negative attitude held towards persons with disabilities has already been discussed. One positive effect is that there appears to be a low incidence of alcohol and drug abuse in the Asian-American community which may be largely due to the cultural sanctions against drunkenness and substance abuse. For example, there are fewer drinking establishments (i.e., bars), in the traditional Asian-American community (Sue, 1987). The use of alcohol in the Asian-American community is limited to special occasions (e.g., at ceremonies and with dinner) (Sue, 1987). However, there are signs of an increase in the incidence of alcohol consumption in the Asian-American community believed to be associated with a growing identification with the American culture and the effects of acculturation (Kitano et al., 1985). Singer (1974) in a study of Chinese residents in Hong Kong found a low incidence of alcoholism. However, he estimated that between six and ten percent of adult males were addicted to opiates, especially opium. Further research on opiate use in Asian-American populations is needed to see if this drug is being abused in the Asian-American community.

Some studies indicate that Asian-Americans are more severely disabled by psychiatric disorders at the time they are brought to the attention of mental health service providers. This may reflect a disinclination to seek help for disabilities until the point of acute breakdown or crisis. In a study conducted in Seattle, Sue (1977) found a far higher proportion of Asians diagnosed as having "psychosis" than other groups. Of Asian and Pacific American patients, 22.4% were diagnosed as "psychotic" compared to 12.7% of white patients, 17.6% of Native Americans, 13.8% of African-Americans, and 14.5% of Chicano patients.

No information was found on the incidence of physical disabilities in the Asian-American community. Just as documentation has provided some insight into the existence of mental disabilities, there is no doubt that physical disabilities exist as

well. The impact of substance abuse on the disabled Asian-American population can only be surmised. The apparent low incidence/prevalence of alcohol and drug abuse diminishes the impact of these conditions coexisting with other physical and mental disabilities. The impact of being a member of one of the ethnic groups within the Asian-American community has its related problems of poverty, inadequate educational attainment, poor health care, etc. Like Cubans, in the Hispanic community who appear to have higher standards of living, it appears that Chinese and Japanese Americans have higher standards of living than more recent Asian immigrants. Based on information regarding poverty issues, an inference can be made that persons living at the lower socioeconomic level are more at risk for alcohol and drug abuse.

Legislative Recommendations

- Establish base line data on the incidence and prevalence of disabilities in the Asian-American population.
- Fund Research and Training Centers to conduct research activities related to Asian-Americans.
- Train and hire more bilingual Asian/Pacific professionals.
- Develop policies which encourage employers to be more sensitive to cultural issues associated with the acculturation/deculturation of Asian-Americans.
- Fund programs developed for and by Asian-Americans with disabilities.
- Assist and encourage the employment of Asian-Americans with disabilities.
- Provide financial funding for community outreach and community education programs.
- Increase transitional activities, e.g., school-to-work, school-to-rehabilitation agency-to work.

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Reaction to Substance Abuse and Disabilities Among Minorities

John C. Smith, MSW
Program Manager
Morehouse School of Medicine
Atlanta, GA

The paper presented by Dr. Brown contains a great deal of information on how substance abuse contributes to the high incidence of disability among minorities. The writer skillfully shows the relationship between income level and the incidence of mental illness. Moreover, there appears to be a greater relationship between substance abuse and persons who have mental and physical disabilities. I agree that drug abuse not only contributes to disability through disease and trauma, but it also continues to be a problem after disablement for timely recovery and full independence.

Substance abuse is significantly correlated with the use of deadly weapons in domestic disputes and criminal activities after leading to gun related disabilities such as paralysis and traumatic brain injury. What we really need is a solution to the problem. Thomas (1987) suggested that historical precedent may provide some solutions.

> "The lowest incidence of Black male homicide was when the Black power movement was visible and flourishing. Psychohistorical data support the contention that racial pride is an effective means for regulating intragroup tension. In the absence of an Afrocentric orientation that promotes community power and self-determination, the need for self-reliance is eroded by value illnesses" (p. 155).

Fagan (1987) argued that "in disorganized communities where social controls are weak or conflicting, opportunities for exposure to criminal behavior and values exist, and youths are at a greater risk of delinquency than in other places through involvement with delinquent peers." (p. 56).

According to Fagan, (1987)

> It was the churches, self-supported benevolent groups, local social networks, and the family that were the guardians of neighborhoods. As these institutions have weakened, so too, have their ability to teach neighborhood youth. Residents in high-crime neighborhoods have increasingly turned to

> social institutions or formal agencies to take up the responsibility of maintaining a safe, comfortable community, socializing young people, providing opportunities for growth and respect, and sanctioning behavior. Such alternative institutions have included the child welfare system, police departments, schools, individual or group advocates, local and national government agencies, and neighborhood-based organizations (p. 55).

Unfortunately, these substitutions have not always been successful alternatives. My recommendation for reducing the incidence of disability in minorities is community organization and development for health promotion approach.

According to Katz (1984), empowerment is defined as access to and control of valued resources. This definition emphasizes establishment of an equitable distribution of resources to enable those presently disenfranchised and oppressed to experience a fair share of the power. If disenfranchised populations are able to be in control over one aspect of their lives, it increases the probability that they will be able to gain control over other aspects as well. Empowerment for health promotion therefore provides a framework upon which many social ills can be addressed; ultimately, all these ills have an impact upon health status.

Empowering Minority Communities

The Health Promotion Resource Center (HPRC) at Morehouse School of Medicine has been established to provide training and technical assistance that addresses primary prevention needs of minority and poor populations. The philosophy of the HPRC is that health promotion efforts are likely to be more successful in these populations when the community at risk is empowered to identify its own problems, develop its own intervention strategies, and form a decision making coalition board to make strategies, and form a decision making coalition board to make policy decisions and manage resources around the interventions. Further, because health and illness behaviors are culture-bound, primary prevention efforts to address preventable disease and illness must emerge from a knowledge of and respect for the culture of the target community.

The major strategy of the HPRC is to organize minority and poor communities to take an active and participatory role in identification of their health problems, the planning design, and implementation of appropriate health promotion programs. In an effort to operationalize the community organization and development strategy, several action steps must occcur: (1) developing a demographic and epidemiologic profile of the target area, (2) initiating appropriate community entry processes, (3) establishing community trust and credibility, (4) learning the ecological dynamics of

the community, (5) organizing a consumer dominated decision making community coalition board, (6) facilitating community involvement in the needs assessment process, and (7) ensuring community ownership through consumer participation in planning and design of the health promotion intervention. The community coalition board must have training to have tools needed to make policy and resource allocation decisions.

Guidelines for Community Organization for Health Promotion

Learning the community

Learning the layout of the community targeted for a health intervention is an essential first step before attempting to enter informal community boundaries. The entry process should begin with a request for geographic and demographic information from local community planning and development agencies. This includes maps which show the basic geography of the target community as well as "block statistical maps" which identify census tracts. The Bureau of Census Neighborhoods Statistics Report provides specific statistical summaries essential to determining neighborhood composition. Moreover, identification of neighborhood resources such as schools, hospitals, health centers, police stations, and fire stations is important.

Community Ecology

Learning the community ecology first hand is essential to the community organization process. This can be achieved by routinely traveling through the community. Familiarization with street layout and the daily cycle of human behavior is essential. It is useful to travel through the community during different times of the day (i.e., morning, afternoon, evening).

Health educators should make mental and written notes of locations where different circles of people gather, where various types of clusters of people converge, where restaurants and stores are located, where churches and recreation centers, schools, and other community facilities are located. Prior to entering the community, the health educator must identify and meet with formal and informal gatekeepers of the neighborhood.

Community Entry Process

It is critical that the "entry process" be negotiated tactfully with community gatekeepers. Tact is essential to developing trusting relationships that are genuine

and non-threatening.

Once accepted by the gatekeepers as a community advocate, the health educator will be "validated" by the formal and informal networks that operate in African American communities. Initially, however, the health educator is likely to be seen as an outsider by the targeted neighborhood. Thus, there is a period of suspicion prior to establishing credibility. Making neighborhood contacts, therefore, is an important step toward establishing an identity in the neighborhood and represents an initial opportunity to express a sincere interest in the well being of the community as a whole. First impressions, in most cases, are lasting ones and are essential, but not sufficient. True credibility will be assured only through time, commitment, and consistency.

Building Credibility

Tangible incentives for community participation should be offered. A viable approach to motivating community residents is to assure them that resources and skills are available to facilitate their taking control over their own destiny. The health educator must be able to convince community leaders and brokers of this if progress is to be made in community organization. After contact with several community leaders, a repetitive theme of community concerns will evolve. The health educator must have a keen ear and identify those problems with which he or she may be able to provide assistance. It is important, however, that one not make a commitment of resources over which he or she lacks control. On the other hand, by donating tokens of minimal resources that address community concerns, one can raise the level of community trust.

Development of a Community Coalition Board

The rationale for initiating a consumer dominated (60 % minimum) coalition board is based on social psychology and community organization principles. Such principles acknowledge the benefits of shared decision making, self-help and self-reliance, reference group ownership of community concerns, and reference group ownership of strategies and approaches to address their community concerns.

It is the responsibility of the board to oversee the entire process of community organization and development for health promotion. This includes conducting a community health needs assessment (a door-to-door household survey utilizing trained and paid community interviewers); taking the needs assessment data with other data to the community to facilitate identification of their health priorities; planning and designing the community based health intervention; and identifying

resources (including applying for funds) to support the intervention project.

Community Needs Assessment

The community needs assessment was designed to assist the community coalition board and the community in identifying what local residents perceived as their most important health concerns. Asking residents for their input communicates the message that they know what their problems are and that their opinions are important. This suggestion promotes self-esteem and the residents are made to feel that their voices can be heard. These benefits are lost, however, unless there is diligent follow-up.

Planning the Intervention

The community coalition board, with the health educator as staff support, should use data collected in the community needs assessment plus its own knowledge of the community, to identify a health problem or problems to be addressed and to select appropriate health promotion interventions. The health educator should serve as a resource person throughout this process and may even offer a "menu" of appropriate interventions of demonstrated efficacy from which the board may review and revise. However, the community coalition board as representative of the community should retain control and ownership of both the problem identification process and planning and design of the intervention.

Summary

The community organization and development process is not new and has its roots in social action ideology from the 1960s. The difference between the 1960s and the 1990s is in bringing together of target community consumers with representatives of private and public sector resources (with consumers in the majority), to form a community coalition board. This community coalition board makes policy decisions. Combining these community organizers and development techniques with the mission of health promotion is a viable methodology for addressing the needs of medically underserved communities.

Reaction to Substance Abuse and Disabilities Among Minorities

Evelyn Davis, M.D.
Assistant Clinical Professor
Pediatrics
Harlem Hospital Center
New York, NY

Drug use by pregnant women in the United States has risen to staggering proportions raising serious concerns not only about the effect on the fetus and developing child but the structure of family life and society as a whole. Cocaine use remains the number one drug of choice among pregnant women in the country with large cities like New York registering a twenty-fold increase in maternal cocaine use during the past decade. I would like to respond to the paper, "Substance Abuse And Disabilities Among Minorities" by paying special attention to maternal cocaine use, its contribution to the increase in developmental disabilities and the specific problems it creates.

While it is true that maternal drug and alcohol abuse can be seen among all classes, ethnic and cultural groups of society, maternal CRACK use has been seen disproportionately among African American women. Seventy percent of women who deliver at Harlem Hospital Center are African American, yet they account for 87.5% of the infants born with cocaine positive urines. The remaining 30% of mothers giving birth are Hispanic, yet account for only 12.5% of cocaine positive urines.

CRACK, which has been sold for as little as two dollars a "hit" (and in some cases dispensed free-of-charge to school children) has remained extremely popular with large inner city populations where poverty, inadequate education, lack of employment opportunities, histories of abuse and neglect and poor sense of self are pervasive. The African American community has been hit especially hard resulting in the tearing apart of the fabric of family life as we know it.

In an article by this author and colleagues entitled "Autism and Developmental Abnormalities in Children with Perinatal Cocaine Exposure" in April 1992 of the Journal of the National Medical Association descriptions are given of a constellation of physical behavioral and developmental abnormalities seen in children with prenatal cocaine exposure (N = 70) referred to the Harlem Hospital Center's Development for evaluation and services between January 1, 1987 and December 31, 1989. Of the 70 referred children, only two were Hispanic with the remainder being

African American. The following revealed:

1. Only 23% of the children were living with their biological mothers. Most of the children lived with the maternal grandmother (40%). Most of the children had been in foster care placement since birth with only five children experiencing more than one foster care placement. It was felt that the foster mothers were caring and concerned and provided good homes for the children.

2. Mean age of mother at the time of child's birth was 27.1 years, much older than one might expect.

3. Poly drug use was very common. All the mothers in our study used cocaine in one form or another during their pregnancy with al least 47% also using alcohol, 14% using opiods, 10% marijuana and 7% PCP. Because we did not have detailed information on many of our mothers, it is suspected that poly drug use was more common than our study revealed.

4. Mean birth weight for the full term infant was 2808 grams, far smaller than the typical full term non-drug exposed infant born at Harlem Hospital Center.

5. Mean gestational age was 36.4 weeks with 44% representing pre-term deliveries.

6. The cocaine exposed children had a mean height age and weight age percentile of 31.5 and 30 respectively, far lower than the norm.

7. Thirty percent of the children had head circumferences below the fifth percentile.

8. Hyperactivity was noted in 30% of the children.

9. Hypertonicity was present in 30% of the children. Five percent of our hypertonic, spastic children have gone on to have frank cerebral palsy.

10. Developmental and behavioral abnormalities were as follows:

a.	language delay	94%
b.	fine motor delay	62.9%
c.	abnormal play	58.6%
d.	social skills delay	54.3%
e.	gross motor delay	37%
f.	autistic disorder using DSM-III-R criteria	11.4%

Data from 1990 were reviewed in order to determine whether there was any change in the spectrum of abnormalities. One hundred children were referred to the Pediatric Developmental Clinic in 1990, a number significantly larger than the total for the three previous years combined. The data revealed a similar pattern of abnormalities with a rate of language delay of 91% and autistic disorder of 6%, somewhat lower than in the first study but, nevertheless, an alarming finding. We are in the process of analyzing the 1992 data. Language delay, cerebral palsy and autistic disorder continue to be major findings in this population of children.

The total number of 170 children evaluated represents approximately 10% of the children born at Harlem Hospital Center between January 1, 1987 and December 31, 1990 and documented as having cocaine in their urines at birth. Unofficial estimates of cocaine exposed born in the United States in 1990 range from 750,000 to 1 million. If only 10% of this estimated number demonstrate findings similar to those noted in the Harlem Hospital Center study, our nation will still be faced with problems of staggering proportions in terms of social, psychological and medical costs to society. In spite of federal statistics indicating a decline in cocaine use throughout the United States, this decline has not been seen in Central Harlem.

It is still not clear how intrauterine cocaine exposure impacts on the brain of the developing child. While there is little controversy about the effect of cocaine on gestational age and weight at birth, there is no scientific consensus on what role it plays in regards to long term effects on cognition, behavior and the ability for function in society. The Harlem Hospital Center's experience suggests that society will have to deal with the fallout for years to come. An analysis of the financial cost of prenatal cocaine exposure in New York City was prepared by the Office of the State Deputy Comptroller for the City of New York in February 1991. "A Preliminary Analysis Of The Impact Of Prenatal Exposure To CRACK In New York City" revealed that by year 2000, incremental Neonatal Intensive Care Unit (NICU) costs for cocaine (especially CRACK) exposed babies for the 1985 - 2000 period will total $104 million. The cost of special education placement will total $765 million. The cost of foster care placement will total $900 million.

The issue of access to care is major for the developmentally disabled child with a history of prenatal drug exposure. Many clinicians are not experienced enough to look for abnormalities that might lead to lifelong handicapping conditions. This is especially true with regards to hypertonicity or spasticity which are often clues of cerebral palsy. If the condition is not diagnosed then the child is not referred for necessary early treatment.

In spite of Federal legislation guaranteeing specialized services for the Zero and above age child with documented needs, there is often a lack of sufficient therapeutic nurseries and other special facilities for these children.

A large number of children living with older caretakers (grandparents, etcetera) often do not have access to specialized services for a variety of reasons:

1. the health needs of the older caretaker which often make it difficult to take the child regularly for therapy sessions.

2. the large number of appointments which must be kept by the caretaker including appointments with the child's primary care physician, the foster care agency, the school system the courts, etcetera

3. difficulties obtaining transportation for multiple visits, and

4. the distinct behavioral and developmental problems of the child which physically and emotionally drain the caretaker and make it difficult for her to keep up with appointments and have faith that treatment actually works.

Drug treatment programs that provide not only for detoxification but full time recovery, that is, treatment for 18 to 24 months are scarce. A pregnant drug abusing mother who is denied treatment will often go on to have more and more drug-exposed infants who will be cared for by alternate caregivers. The mother, unfortunately often becomes an outcast from her family.

Children born with prenatal drug exposure are at much greater risk statistically of developing HIV infection than those not prenatally exposed. HIV in the African American female and child has risen astronomically as the drug crisis have risen. The use of CRACK is closely associated with HIV infection because of the increase in sexual activity with multiple sex partners. The large HIV Team at Harlem Hospital Center struggles day-by-day dealing not only with the issues of repeated illnesses and ultimately death but with the emotional toll the illness takes on every member of the child's family. As would be expected, many of the mothers of the children have already died.

The recommendations so beautifully outlined in the paper are commendable. I would like to add one more. It is imperative that more monies be made available to researchers in the field of drug abuse. Research dollars are often given to researchers already known in the field rather than primary clinicians making keen observations while going about the task of caring for drug-exposed children and their families. The scientific community has said very little about the long term effects of cocaine exposure in utero. In our silence, we have given mixed messages to pregnant women. Our observational data at Harlem Hospital Center tell us that cocaine is a teratogen and the negative consequences can be lifelong for the child, his family and this nation.

EDUCATION

Educational Needs Of Minorities with Disabilities

Frederick D. Bedell, Ed.D.
President
Del-K Educational Consultancy Services
Albany, NY

Introduction

The purpose of this paper is to stimulate discussion around the placement of minorities and the service delivery to minorities in special education programs in public school systems. It is hoped that the discussion will lead to a framework for policy development in this area. The writer will use relevant research data and a background of thirty-two years of experience in public service and public education, to place this issue into a policy framework.

My experiences as a student in both the parochial and public school systems and as a public school teacher have given me a negative perspective of public education. In addition, my experiences as a public official, elected and appointed, have extended this perspective, especially as it applies to education programs for minority youth.

The following observations are of primary concern to me regarding the impact of education on minority children and youth:

* There are school practices that have had negative effect on student achievement, particularly on that of minority students. These practices often cause:

* The disproportionate placement of minorities in special education programs, and

* Minorities remaining in special education programs longer than non-minorities.

In addition, there are societal factors that impact on the school's ability to teach and the student's ability to learn. Schools are generally geared to deal with the student whose behavioral difficulties are mental. However, students were learning problems which can be traced to environmental factors, i.e. malnutrition, mothers addicted to alcohol and drugs. There is a greater unpredictability about these at-risk children as a consequence of the turmoil in their lives when compared to students whose impairments may be attributable to other causes.

It is within this context that the issues of educating minorities with and without disabilities will be considered. Moreover, there are a number of educational initiatives at a national level that speak to the problems existing with the entire education system in the United States. It is my feeling that we cannot address one part without looking at the whole system.

The National Council on Disability, an independent federal agency, charged with reviewing all laws, programs, and policies of the federal government affecting individuals, recently issued a study: The Education of Students with Disabilities: Where Do We Stand? (1989). The study cites a number of number of findings and makes specific recommendations for educational policy makers. The Council's studies are timely because education is at the top of the federal administration's policy agenda.

The President of the United States is so concerned about education that he recently convened all the governors of the states in an "Educational Summit" to draw up a blueprint for the reform of the country's educational system. The outcome of the Summit was the America 2000 Program, which speaks to the restructuring of the educational programs in the U.S.

In concert with the President's education initiative, the business community has come to recognize the need for an educated and skilled work force to maintain America's economic position in a global marketplace. The business community has joined the President to assist the administration in redesigning our educational system.

When we consider the President's and the governors' priority for education reform referred to as America 2000, the business community's call for improved education programs, and The National Council on Disability's study, it is evident that education is not working. **It needs to be fixed.** It is my opinion that we cannot serve disabled students, **minority or non-minority** adequately, without serving the total population. In other words, we need a new education model for all students based on the President's premise that **ALL CHILDREN CAN LEARN AND WE HAVE THE RESOURCES TO TEACH THEM.**

The paper will present some data about the overrepresentation of minorities in special programs and some recommendations to prevent their placement in these programs. In addition, recommendations are made that should improve the placement process of children with special needs. Finally, systems to assure adequate service delivery for this population will be presented.

Review of the Literature

One question often asked, is what is it about school practices that affects the school's ability to teach and the student's ability to learn? This is a complex question with no easy answers. Over the past decade, society has experienced a demographic revolution. Our society has become increasingly diverse as a result of the

immigration of Hispanic and Asian peoples. Language and cultural diversity are having a profound impact on the country's social institutions. In addition to this social phenomenon, we have experienced a major alteration in the households headed by males, females, and teens. There is also the complexity and pressure of living today. We have more households today with both parents working than ever before. We also struggle with the plight of the homeless. What does this demographic revolution mean to schools?

The school has become the focal point of the demographic revolution as it applies to our students' growth and the delivery of educational supportive services. The National Commission on Excellence Report, A Nation at Risk (1983), brought two concepts into the forefront of education: the interdependence of an achieving nation and achieving students; and the idea of being "at risk" - a term now used to describe children whose potential is undermined by health, social, educational and/or economic factors. This complex condition presents us with an education environment that is fraught with complicated dilemmas. One of these is the disproportionate placement of minorities in special education programs, which is the thesis of this paper.

The Placement of Minority Students in Special Education Programs

Several observations regarding this issue were reported at a conference sponsored by the National Alliance of Black School Educators as part of the Charles D. Moody Research Institute's policy forum held in Ann Arbor, Michigan, in 1989.

Don Clark, administrator at the Pennsylvania Department of Education, presented a paper to the National Alliance of Black School Educators (1989) in which he stated that if in the classifications used by the American Association on Mental Deficiency, you could not find any reason to classify any child under the seven definitions listed in their manual due to psychological reasons, you could find an eighth classification based on the functional history, the low income, and low family academic functions. This eighth category could be used to classify the child as educable mentally retarded. He also stated that with the passage of Public Law 94-142, ten million children were identified as educable mentally retarded. 7.5 million were identified as educable mentally retarded and of that population 43 percent were African American.

Ruth Love, former Superintendent of Schools in Chicago and Oakland, stated that 85 percent of the students in the special education programs in Chicago were African American. This situation brought her to the conclusion that one of the goals of the special education program must be to get kids back into the mainstream.

The Assistant Secretary of the Civil Rights Division (1990) focused his objectives for the department on the area of ability grouping, the treatment of children whose native language is other than English, and the disproportionate placement of minority children in special education classes. In September 1987, the New York State Education Commissioner appointed a Task Force on the Education of

Children and Youth At-Risk (1988). The charge to the task force was to recommend to the Commissioner and the Board of Regents a comprehensive, long-term strategy for improving the education of at-risk children and youth. One of the task force recommendations was to revise practices as necessary, of special education programs to ensure accurate referral, assessment and placement of at-risk children, and to avoid stigmatizing students.

The Education of Students with Disabilities: Where Do We Stand? (1989), cited a number of findings along with specific recommendations for educational policy makers.

Finding #3: Parents and students report that some schools have low expectations for students with disabilities and establish inappropriate learning objectives and goals.

Finding #4: Services often are not available to meet the needs of disadvantaged, minority, and rural families who have children with disabilities.

Finding #18: Special education is a relatively separate system of service delivery.

Finding #20: Current pedagogy regarding effective schools and teaching practices can facilitate the integration of special needs students into general classrooms.

As a direct result of the findings of the study, the National Council raised questions regarding the relationship between educational settings and student outcomes, the feasibility of enhanced Federal-state partnerships, and the consolidation and improvements of special education and general education for all students.

The National Council considered the findings so important that it commissioned another national study: Serving the Nation's Students with Disabilities: Progress and Prospects. This study attempted to address questions unanswered in the first report including:

* Where do students with disabilities fit into current education reforms, such as America 2000 and the fall 1991 Report Card on the Status of Education in America (1991)?

* Do students with disabilities receive equitable treatment in education assessment and research programs?

* Are traditionally neglected and underrepresented students shuttled away from their non-disabled peers and placed in programs that do not fit their needs?

* How can special education and general education systems work together, across federal and state and local levels, to ensure that students with disabilites will achieve valued outcomes?

The Education for All Handicapped Children Act (1975) did little to acknowledge the unique needs of Hispanic or language minority children in special education, (Figueroa, 1989). He suggests that Public Law 94-142 was silent on Hispanic pupils (15% of the population at the time). The evidence suggested that misplacements in special education programs were not benign, and the miseducation of bilingual children may well have been the norm. Irrespective of bilingual education, controversy surrounds different methodologies for the delivery of bilingual education. Linda Chavez, a former White House aide, recently published a book entitled Out of the Barrio: The Assimilation of Hispanics into the Mainstream. She states that a survey of Mexican-American parents indicates that Hispanic parents want the school to concentrate on teaching reading and writing in English to their children. This is a change from the traditional bilingual education programs that are currently available in public schools. She feels that the dual system is supported by the bilingual educators to maintain their jobs.

So what does all of this mean? In this writer's opinion, it points to an education system that is on overload, confused and bogged down. It is apparent that there are a number of conditions that put students at risk. Poverty, the impact of racism, cultural differences, and the weakening of the home influence are many contributing societal factors. Moreover, low self-esteem, peer pressure, lack of self-discipline and life goals coupled with the school factors of inappropriate curricula, inadequate school services, and, in some instances, a hostile school climate often lead to students' failure in school.

As mentioned earlier, the profile of the student in question does not fit the student with a disability syndrome. Rather, the student of concern fits into the category of a social syndrome that impacts on his ability to learn. At the same time, the school is ill-equipped to deal with this youngster because of inadequate teacher training or inappropriate curricula, and, as a consequence, places that student into a special education programming track.

Every day the gap is widening between the program options available to students in affluent/stable communities and children who attend schools in less affluent communities. All too often, at-risk children find themselves in failing schools which have the least resources, physical plants in deteriorating conditions and the most dispirited and least inspired teachers. Teachers often find themselves ill - trained and overwhelmed as they attempt to work with as many youngsters as possible. Many students fall between the cracks or are misplaced and too often written off. It is within this educational climate that referrals to special education programs occur, often with good educational intent, but more often than not, for the wrong reasons.

After working for thirty-two years in public education, I have come to the

conclusion that we need to refocus our educational priorities and concentrate on the restructuring of our educational system. The next section of the paper will attempt to spell out what is wrong and what can be done about it.

Personal Observations

My experiences as an educator and public official in the educational and public service fields have enabled me to draw a number of conclusions about educational programs, both regular and special. My first premise is we should keep students out of special education programs whenever and wherever possible. Once students enter the system it is very difficult to get them out. Secondly, I feel that general education programs properly adapted can serve a large number of students presently placed in special education programs.

Gardner and Lipsky (1989) present an excellent summation of the positions to merge educational services into a unitary system. It is their position that attitudes and assumptions about the disabled and disabilities require change as do the inadequacies in general and special education practices. They call for a unitary education system - "an educational model for all students that is supple, variegated, and individualized- in an integrated setting".

Students enter school (kindergarten level) ready to learn and eager to get involved in the school program. Observe any kindergarten class and you will see kids having fun. They are talking, working with materials, experimenting and interacting with each other and their school environment. When the kids enter the first grade something happens. Sometimes school isn't fun anymore. We educators begin the regimentation process. We put students into tidy rows. We limit their movement around the room. We discourage students from talking to each other. We make them raise their hands to ask questions. The fun and spontaneity of learning is gone. I maintain this structure is designed to control behavior of students and impedes the learning process.

When I was a principal of a special education facility with a program design of an open classroom/education methodology, there were certain elements about the program that shaped my attitudes and beliefs about education in general. Dr. Stephen Glenn, a noted family life expert offered a theory as to why youth are at risk today (1989). He feels that our schools are in trouble primarily because the world around us has changed and schools have not changed. Today's schools were originally designed to meet the needs of an agrarian economy and then adapted somewhat to address the needs of an industrial economy. Our schools are just not well suited to meet today's business needs or the needs of a diverse student population.

He looks back in time at the one-room school house and the good teaching practices that occurred in that environment. Older students often served as tutors and mentors for younger students. There was more sharing and collaboration and less competitiveness in that teaching and learning situation. Children felt their time,

effort, and work were validated. They felt affirmed. They gained self esteem and self-worth.

KIDS FELT GOOD ABOUT THEMSELVES.

In the open classroom approach, an environment was designed absent of classroom walls. Learning space was conducive to kids interacting with other kids and staff. Teachers could easily talk to other teachers and staff members. Both teachers and students could easily access learning materials. The students thrived in this environment. Older youngsters helped younger students in a family type setting. There was an absence of tension. Self-esteem was enhanced and as a consequence achievement went up. I feel that the traditional school environment restricts free movement of students and may be an impediment to the learning process.

One common practice used in schools is ability grouping. In my opinion, grouping students by ability hurts more than it helps a student. A fellow friend and educator, Carl Boyd conducts education seminars around the country using the theme: **NOBODY RISES TO LOW EXPECTATIONS.** Grouping students by ability, particularly for those students in the lower groups, sends a message of low expectations. "Sixty Years of Research Finds Grouping Students by Ability Doesn't Increase Achievement" was the conclusion drawn from the research of Dr. Robert E. Slavin of Johns Hopkins University (1989).

Why do we group students by ability? One could argue that it is done for the benefit of the teacher. Teachers feel that it is an effective teaching method. Tracking/ability grouping began in the early 1900's as a means of dealing with immigrant students to maintain social control. Still today we find that the majority of students tracked into vocational and non-academic courses and grouped in lower achieving sections are minorities - primarily African American and Hispanic students.

The negative school practices cited above damage a student's self--esteem. Without self-worth it is almost impossible to succeed. Low self-esteem is an addiction, a state that seems to underlie afflictions as diverse as bulimia and performance anxiety. "People see that self-esteem is a component of so many other things - teenage pregnancies, dropouts, drugs and school success", states an article in the magazine Newsweek (1992). Let's talk self-esteem to a positive dimension. Eugene Lang, a noted philanthropist, sponsored a sixth grade elementary class from East Harlem, New York City Elementary school. He guaranteed college tuition of the students if they completed high school. The sixth grade prior to Mr. Lang's sponsored grade had a 25% high school completion rate. Mr. Lang's class had a 75% high school completion rate. Research of the classes revealed that Mr. Lang gave students hope and a new vision. Affluent kids have hope and feel they have the power to control their destiny. Less affluent kids, by contrast, feel powerless to control their destiny. They feel their future is controlled by fate. Mr. Lang's program changed their outlook. He gave them hope.

NOBODY RISES TO LOW EXPECTATIONS - says Carl Boyd. It is apparent

that certain school practices are affecting minority students' achievement and are a direct cause of referrals to special education programs. The challenge to all of us is what can be done about it.

Recommendations

We Need A New Model.

What America expects of its public schools these days is nothing less than miraculous. Never mind that the children who show up for their first year of school may have lived their early childhood in chaos. The Unfinished Agenda, a study released by The Committee for Economic Development (1991), takes the position that a child's education begins at birth. If the child is deprived of physical and emotional nourishment and intellectual stimulation, the child's teachers will have to play catch-up. That teachers often lose the game is all too clear. The report proposes expanding the Head Start preschool program to enroll every eligible child; it also endorses easier, broader access to prenatal care and childhood immunization and calls for a collaborative effort from all sectors of society.

The Carnegie Foundation for the Advancement of Teaching recently published a report - **Ready To Learn: A Mandate For The Nation** (1991) in response to President Bush's goal that all children should enter school ready to learn (America 2000). The report lays out an extensive plan showing how we can, as a country, get our students READY TO LEARN. Therefore, my first and foremost recommendation is to focus on preschool programs, particularly in less affluent areas of the country.

My next recommendation deals with restructuring the schools and, in particular, eliminating perceived negative school practices. We need to go back and take a page out of the successful methodologies used in the one-room school house. A number of schools are experimenting with what is called collaborative work cultures/cooperative learning. Cooperative learning is the practice of students working together to solve a problem or work on a project. The emphasis is on cooperation rather than competition. We do not need to segregate large numbers of students into separate classes. We need to find more ways to mainstream our diverse student population. Collaborative work cultures/cooperative learning is one way of achieving this goal.

My final recommendation addresses the referral and placement process of students. It has been well documented that minority students are disproportionately placed into special education classes. To alleviate this practice we need a system that holds staff members accountable and responsible. We need to look at Individual Service Planning for all students. We need a comprehensive system that puts forth strategies for services based on the theory that students have different needs which require different services. The school must be able to develop and modify plans according to the student's needs. Since different kinds of students have different needs which require different services, schools should provide a variety of services and recommend students to various programs according to current needs. I think

one answer to this dilemma is **Individual Service Planning. We need to develop funding to make this work**

In Summary

The education system is broken. It needs to be fixed.We cannot meet the unique educational needs of minorities without meeting the needs of the total school population. I recommend focusing on Readiness to Learn programs, changing negative school practices that impact on a student's interests and ability to learn, and, last but not least, holding the staff accountable and responsible for a student's progress through Individual Service Planning.

A former boss of mine said it this way: "When we all arrive on this earth. we are expected to paint pretty pictures. However, when we open up our paint boxes, some of us find that all of the colors are not there, or they may be chipped and diluted and the paint brushes are either broken or missing". In this context we need to help all kids paint the pictures they are capable of by providing them with the necessary equipment and resources **so that each one can become all that he/she can be.**

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Reaction to Educational Needs of Minorities with Disabilities

Tennyson J. Wright, Ph.D., CRC
Assistant Provost/Associate Professor
University of South Florida
Tampa, FL

I want to thank the National Council on Disability for the opportunity to present today and to respond to Dr. Bedell's thought provoking paper. Dr. Bedell has provided a very insightful articulation of the unique educational needs of minorities with disabilities. His vast experience as an educator, administrator, and consultant has provided him with a keen insight into the problems and challenges which face minorities with disabilities in the educational system. Among the issues which he has addressed, and with which I agree, are:

- School practices have a negative effect on student achievement, particularly minority students.
- There is a disproportionate placement of minority students into special education.
- Minorities remain in special education programs longer than non-minorities.

He has identified several environmental factors which contribute to the disabilities which affect these students. Among them are:

- Malnutrition
- Mothers addicted to drugs
- Poor prenatal care

I might also add that among other factors are:

- Racism
- Sexism
- Little or no health insurance for the millions of minorities in America (in fact, Hispanics are the largest population in America today without

health insurance, followed by African Americans -- the smallest number are white Americans.)

- Alcoholism and drug addiction of minorities, and
- Exposure to dangerous health conditions in the workplace.

Dr. Bedell has also addressed the findings of *America 2000 Program* which emerged from the Bush administration and the National Council on Disability's findings and recommendations in *The Education of Students with Disabilities: Where Do We Stand.* These two studies identified specific recommendations for education policy makers and reformers of the country's educational system.

In addition, we must not forget the challenges to education that grew out of *Workforce 2000, Opportunity 2000,* and *The Bottom Line: Basic Skills in the Workplace* which were commissioned by the Department of Labor and published by the Hudson Institute. These documents challenged government, education, labor, and the general public to prepare today's youth, including persons with disabilities, to prepare for the changing education and skill needs and demands of the year 2000.

Now, let's turn to the thesis of Dr. Bedell's presentation: *The Placement of Minority Students in Special Education Programs.* As he has noted, far too many minority children in the public education system are labeled as mentally retarded, hyperactive, slow learners, developmentally delayed, problem children, etc. He has noted that the system continues to label these children who come from the poorest families in America and condemn them to a lifetime of imprisonment as "mentally retarded" -- a sentence from which few escape and even fewer educators and government officials care to do anything about.

What he did not say directly, but alluded to, is that this educational system "blames the victim" of the labeling for being:

- Poor
- Victims of racism and prejudice
- Disabled
- Members of minority, racial, and ethnic groups
- Uneducated or undereducated
- Institutionalized victims
- Devalued as human beings
- From the other side of the tracks
- Underemployed or unemployed

The system of education fostered in America today supports a program which can be viewed as one which is a "Deficit Model" -- identifying and focusing on what minorities do not have and as measured against a "white European standard of able bodied persons." Such a system utilizes assessment methodologies, teaching methodologies, pedagogical techniques, and achievement standards which are racial

and ethnic, gender and class biased. For example, standardized test instruments were developed by white Europeans based upon white European norms and applied to individuals who are not represented in the norms. From a purely psychometric perspective, such test instruments are by definition not valid nor reliable instruments for use with minorities and particularly minorities with disabilities. Yet, the results are treated as if they were valid and reliable measures of intellectual functioning and the student is too often labeled as "deficient," "retarded," "developmentally delayed," "learning disabled," etc. The problem does not lie with the student but with the test developer, corporate manufacturer and producer, educational system, government, and practitioners who are too ignorant to know the difference between a "bad test" and an individual who is different from the population norm. This is a true example of neglect, abuse, and professional malpractice. Until Americans, like you and me, say "enough is enough," the abuses will continue.

Dr. Bedell has reviewed the literature and presented an excellent, though brief, overview of education in America. He has noted that the self-esteem prevalent in the one room school is absent in American education today. He has recommended that the education system return to the philosophy and methodologies of yesteryear when education and learning were fun and exciting for the educator and the student. He has also recommended a new model of individual service planning.

Let me add to those recommendations: We need to educate the educator, the psychometrician, the test developer, the school administrator, and others about the real America of populations of Asian Americans, African Americans, Native Americans, and Hispanic Americans with disabilities.

- We must overhaul the education system by developing a liberal education of inclusion and not exclusion relative to the values and difference inherent in

  - Race
  - Culture
  - Gender
  - Disability
  - Class
  - Language

- We must educate Americans about the growing division of this country into two classes -- separate and unequal and prevent its continuation.

- We must install values in Americans which appreciate differences as not good vs. bad but rather human and natural.

- We must educate Americans about the ability and not the disability.

- We must recruit, educate, and employ more minorities and minorities with disabilities.

- We must educate Americans about the Americans with Disability Act as a civil rights act which protects the educational rights of children with disabilities.

You and I are responsible for today's condition and we must take responsibility for changing the way in which minority children with disabilities in the educational system are abused and neglected. We can change today or pay the price tomorrow and for generations to come. Again, I wish to commend Dr. Bedell for his excellent paper.

Thank you.

Reaction to Educational Needs of Minorities with Disabilities

Dr. Julian Castillo, Director
Division of Health Related Professions
The University of Texas - Pan American
Edinberg, TX

Muchisimas gracias, es un gran placer en estar aqui con ustedes para compartir en esta conferencia. Thank you very much, it is a pleasure for me to have been invited to participate in this conference. My role today is to react to Dr. Bedell's paper. He stated that "' there are societal factors that impact on the school's ability to teach and the student's ability to learn". Dr. Bedell goes on to say that the educational system should be considered as a whole and not separated in addressing the issues of educating minorities with and without disabilities. I am in full agreement with Dr. Bedell on this point. The educational system must provide for access to the full array of educational opportunities consistent with the student's intellectual abilities.

Dr. Bedell points out that "our society has become increasingly diverse . . . . The language and cultural diversity are having a profound impact on the country's social institutions". It is important that we have a good understanding of the various minority groups we are attempting to serve in order that informed decisions result in public policy that is culturally sensitive and effective. The planning process for delivery of services requires an understanding and knowledge of the population to be served. This contention is supported in a report by Development Associates, Inc. "Historical trends and projections in the size, composition, and geographic distribution are among the characteristics of the Hispanic population that are needed to determine what type of services are required and where these services should be located. Without this information, it is extremely difficult to assess the adequacy of present programs or to plan for the future needs of Hispanics". The Hispanic populations consist of a number of sub--groups with different origins. This diversity contributes to distinctive cultural characteristics, thus requires an understanding of the sub-groups encompassed in the term Hispanic. As the saying goes, IF YOU DO NOT KNOW WHERE YOU ARE GOING, HOW CAN YOU TELL THAT YOU HAVE GOTTEN THERE.

Dr. Bedell states that poverty, racism experiences, and cultural differences places students at risk. Dropout rates must be added to these factors. It is evident from the data just presented that Hispanic youths are definitely at risk. Dr. Bedell

also indicates that we have "an education system that is on overload, confused and bogged down"". There is a need for change which includes a process that will provide for accountability. The University of Texas Pan American is presently involved in establishing the Center for Professional Development and Technology. The Center will implement a program to prepare teachers and provide continuing education in order to meet the needs of the students being served. The University is located in an area where the population is 70 to 85% Hispanic. Maybe this project can provide a model program that will address the concerns expressed by Dr. Bedell including inappropriate curricula, inadequate school services, and a hostile environment. According to Dr. Kevin Morse, a Center faculty member, the Center is tied to the current trend of accountability in state government. Dr. Morse states that "accountability is the big thing . . . . . The way you make a difference is by proving that when you teach, somebody learns. We're going to look at insisting that student[s] [teachers] give us evidence that they've taught somebody something before they get certified to teach". This project attempts to address the issue of accountability.

Dr. Bedell believes that "grouping students by ability hurts more than it helps a student". The concept of grouping is a concern, but not a great concern to me. However, the misplacement of students, a great concern of mine, needs much more attention. This is consistent with Dr. Bedell's concern "that the majority of students tracked into vocational and non-academic courses and grouped in lower achieving sections are minorities --primarily African American and Hispanic students". It is my belief that the misplacement of the Hispanic youth is exaggerated because of limited or absence of English communication skills. Bilingual education has attempted to address this problem but has not resulted in significant outcomes. Granted, there has been some improvement but the numbers of Hispanics graduating from high school or college have not increased significantly. According to a report in the April 2, 1992 issue of the Higher Education and National Affairs, "minority representation among master's recipients changed little from 1979 to 1989, growing from 10 percent to 11 percent." Dr. Bedell stops short of saying STOP THE WORLD, LETS START OVER, THIS TIME WALKING IN CONCERT WITH THE MUSIC. There is a need to provide what Dr. Bedell has described -- effective preschool programs, focusing on the low socioeconomic population; collaborative work cultures/cooperative learning and Individual Service Planning. I agree that these approaches would contribute greatly in bringing the educational system up to date and prepare it for the year 2000.

In conclusion, let me add my observations as to what our educational system must consider in order to provide a more effective learning environment for minorities with and without disabilities.

The educational system(s) must:

* Have a better understanding of the ethnic/cultural differences of the population they are and will be serving.
* Have knowledge of the demographics of the future

* Provide for family involvement
* Promote and support discipline at home and school
* Promote and support cultural sensitivity training for
  - School Boards
  - School Administration
  - Teachers/Faculty
* Provide for system flexibility
* Use of team approach to teaching and learning

It was at a conference on Wellness in the Worksite, a presenter described the term TEAM as the acronym for

T-OGETHER
E-VERYONE
A-CCOMPLISHES
M-ORE

Thank you, mil gracias

WORKSHOP REPORTS

Concurrent Workshop
Session I
Employment

Moderator: Dr. George Oberle

Presenter: Ms. Alyce Jenkins

Panelist: Mr. Claudie Grant
Mr. Loran Graham
Dr. Daniel Wong

Reporter: Dr. Louise Jones

Major Focus: Problems minorities encounter obtaining employment. Attention focused on the implications of disability and poverty on securing and maintaining employment, and exclusionary practices of employers, labor unions, educational systems, and public rehabilitation programs.

The paper presented in this session on employment focused on three areas:

1. Disability and poverty as they impact employment opportunities for minorities with disabilities.

2. Exclusionary employment practices of employers, labor unions, educational programs and public rehabilitation programs, and

3. Recommendations which can be used to influence policy and legislation.

Minorities addressed in the paper include African American, persons of Hispanic origin, American Indian/Alaska Natives and Asian American/Pacific Islanders:

The following points were discussed:

1. Research clearly indicates that disability and poverty directly impact the experiences minorities have in employment. Studies by Wright, Braddock and McPartland, McConnell and Asbury were cited.

2. In terms of exclusionary practice, the omission of reference to persons with disabilities from a list of factors which will shape the future economy in Workforce 2000 - Work and Workers for the 21st Century, (Hudson Institute Report, 1987) is noteworthy.

3. There is a need to hire more persons of color and persons with disabilities as rehabilitation counselors with vigorous recruitment efforts.

4. Awareness of prejudices toward disabilities must be recognized and alleviation must take place through education.

5. Efforts should be made to present employment issues before persons in position of influence and authority in the community.

6. Mississippi is not alone in the difficulties individuals with disabilites and minorities have in getting employment. It is nationwide -- it is tough everywhere.

7. **Recommendations from panel:**

   - There should be a national policy on employment of minority persons with disabilities, then enforcement can be legislatively mandated.

   - We must deal with the hearts, minds and attitudes of people so that a sensitivity level can be developed.

   - Place more emphasis on ability by matching skills and maximizing potential.

   - Analyze the labor market demand for job and intensify training programs.

   - Emphasize "getting a job because of ability, not because of disability."

General recommendations from the paper presented were as follows:

1. Analyze practices of Labor Unions and the Legislature which prevent them from being very active in hiring persons with disabilities.

2. Organize a Task Force to oversee the Rehabilitation Services Administration regarding delivery of service to communities which are, at a minimum, representative of the social makeup in the various states.

3. RSA should give statistical credit to Rehab Counselors (VR agencies) for the number of minorities brought into the system as well as those who are successfully rehabilitated.

Concurrent Workshop
Session I
Research

Moderator:	John A. Gannon
Presenter:	Dr. Paul Leung
Panelist:	Dr. Jean Farish Dr. Sylvia Walker
Recorder:	Dr. Earl Leggette
Major Focus:	The purpose of the workshop was to develop a research plan for addressing unique needs of minorities with disabilities using the papers as the bases for the plan.

Dr. Leung presented the research needs related to minorities with disabilities. His paper focused on the current status, current knowledge, demographic, access, assessment and eligibility issues, culturally specific rehabilitation, and recommendations.

Initially, he described the Americans with Disabilities Act (ADA) as a milestone in civil rights legislation for persons with disabilities and Americans in general. He acknowledged that ADA is patterned after two other pieces of civil rights legislation: the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. He noted that the three models described in the work of Sue, Arredondo, and McDavis (1992) suggested that "white middle-class value systems are reflected in counseling and social psychological research regarding racial and ethnic minorities". The models are the inferiority or pathological model, the genetically deficient model, and the culturally deprived model. He stated that they are particularly harmful and should not be used as a guide for conceptualizing research on racial and linguistic minorities. He cited one of the more comprehensive reviews of literature as that done by Wright and Emener (1989) and released as an annotated bibliography with 526 entries across four minority populations – Asian Americans, African Americans, Hispanic Americans, and Native American. Of the 168 on African Americans, only 34 were concerned with general disability. For Hispanic, only 14 of 76 and Native American only 12 of 196. In another study, both Blacks (13.7%) and Hispanics (8.2%) have higher work related disabilities than whites (7.9%). He noted that the bulk of this research was funded by the National Institute on Disability and Rehabilitation Research at Howard University, the University of Hawaii, and Northern Arizona University.

He noted that there is not a clearinghouse or data base that provides for disability or rehabilitation research related to these populations. He pointed out that current methodologies used in sampling need to be broadened to enable analysis of smaller units. All programs that are federally funded should be required to feed the data back into the system. There is misunderstanding of minority groups. For example, Asian Americans are sometimes reluctant as a group toward receiving government help, even though "virtually all Southeast Asian refugees begin their American lives on welfare".

Dr. Farish noted that minorities and disability persons need to be taught to cope with society; there is a need for research conducted on minorities by minorities; a need for field-based research; a need for rehabilitation profession as well as service providers; a need for adequate sampling, data analysis, integration, mainstreaming, and empowerment. In general there is a need for a comprehensive needs assessment to facilitate culture awareness training and to plan and develop programs that are designed to address the unique needs of ethnic minority persons with disabilities. There should be more field-based research and field-based prevention programs.

Dr. Walker stated that the ADA is a promise, but we need to work toward making it a reality. Disability can not be viewed in isolation to ethnicity and race. There is a need for ethnographic studies. The research must include phases rather than look at a group for two or three years and then make a recommendation. In general, the organization should strive to respond to diversity, capability, and ability of minorities with disability. Research should be coupled with intervention strategies and collaborative varity of support systems in the community.

From the audience-dialogue, it was suggested that there is a need to look at people in jobs and determine why they were placed there and what their upward mobility and/or instinct was. Also, there is a need to survey the community to determine exactly what their priorities are because students from small towns like Mount Bayou and Canton have a much different cultural and economic background and outlook than students from urban areas. It was pointed out that some of this data is public record and is available but maybe hard to get. One source of help on obtaining data is the Office of Rehabilitative Services, Commissioner Nell Carney, phone 202/732-1183. There is a need for counselors to work and form partnerships with state personnel boards and state agencies to determine priorities.

Summary:

1. The method of collecting, analyzing, and utilizing data on this population is not working.

2. Some data is available but is not accessible or not in the usable form.

3. There is a need for a needs assessment in this area.

4. The welfare of minorities with disabilities is a definite problem area.

5. Ultimately, there needs to be a set of standards for addressing the general and specific needs of ethnic minority persons/groups/people who have disabilities.

Concurrent Workshop
Session II
Rehabilitation

Moderator: Dr. George H. Oberle

Presenter: Dr. Frank Giles

Panelist: Dr. Madan Kundu
Dr. Eddie Glenn
Dr. William Talley

Reporter: Dr. Gloria Dansby-Giles

Major Focus:

As I attempted to do so, it became apparent that my summary would be explained through the eyes of a person trained in school and private practice counseling and not through the eyes of a rehabilitation professional. My knowledge of the field of rehabilitation has been through association with a significant other. When my husband read the summary last night, he responded by asking, "Was I in that session?" Perhaps this will prepare you for this report.

The summary has been categorized into two areas which I borrowed from Carl Boyd - "Nobody Rises to Low Expectations" and "Somebody Rises to New Opportunities." Within the first category of "Nobody Rises to Low Expectations," we find that the barriers to quality rehabilitation services are unique to each of the four ethnic groups studied which included African Americans, Hispanic Americans, Asian Americans, and Native Americans/Aleutians and Pacific Islanders. Some of the 356 common problems shared by all minorities with disabilities are:

1) They are more likely to be found ineligible for rehabilitation services;
2) They are less likely to be rehabilitated and to receive vocational training;
3) Less costly rehabilitation services are provided for them; and
4) They have a double jeopardy which presets significant barriers to employment.

These findings clearly reflect Carl Boyd's opening theme -- "Nobody Rises to Low Expectations."

The second category of -- "Somebody Rises to New Opportunities" encompasses the recommendations. While I will not attempt to identify all of thee recommendations, I will share a few of them with you today. They include:

* Study the stated barriers to determine whether they are true barriers to rehabilitation services for minorities;
* Research and examine counseling approaches that are effective with minorities in private-for-profit rehabilitation programs and public programs;
* Overhaul the state rehabilitation system as well as increase the number of minority rehabilitation counselors;
* Initiate cultural awareness training in the form of in-service workshops for rehabilitation professionals;
* Promote the recruitment and financial support of students entering rehabilitation counseling programs especially minorities;
* Infuse cultural diversity issues across the rehabilitation counseling curriculum;
* Continue to work with RSA and encourage it to financially support rehabilitation training programs in HBCU's;
* Develop outreach programs that take services to the various cultural groups; and
* Address the language barrier as an obstacle to quality rehabilitation services for some ethnic groups.

In this session, I was overwhelmed by the spirit of cooperation, motivation, dedication, commitment and persistence of rehabilitation professionals along with the wealth of knowledge and recommendations. Being equipped with these qualities, we can whammy this double whammy of disability and disadvantage with the double opportunity --- the opportunity of being eligible for services and the opportunity to receive quality services.

Thank you.

Concurrent Workshop
Session II
Empowerment

Moderator:	Dr. Ivory Phillips
Presenter:	Ms. Eva Britt
Panelist:	Ms. Cheryl Wu Ms. Kaye Gainer
Recorder:	Dr. ReJohnna Brown
Reader:	Ms. Phoebe Moffett

It has been estimated that 10% of the world's population, or more than 450 million people, are mentally retarded or physically disabled The incidence of disability is increased by malnutrition, disease during pregnancy and early childhood. About 250,000 children lose their eyesight due to the lack of Vitamin A. Over the past 20 years, the Developmental Disabilities Movement has been a growing part of American life.

Negative attitudes toward persons with development disabilities have been changing and society is beginning to recognize that these individuals have the right to acquire education, job skills and to lead fully integrated and productive lives. The Americans with Disabilities Act of 1990 should receive credit for bringing to light the needs, interest, wants and desires of all persons with disabilities.

The panelists pointed out that "There is still a lack of genetic counseling, testing and a shortage of accessible housing for disabled minority persons".

Several organizations have influenced the Office of Civil Rights to fund and provide outreach services to ethnic minority persons with developmental disabilities. The state of California (Asians); Arizona and New Mexico (Native Americans); District of Columbia (Urban Hispanics); West Virginia (Rural African Americans); and Maryland (Urban African Americans).

These projects made significant gains in identifying and assisting these various ethnic groups in their struggles to obtain their rights.

Concurrent Workshop
Session III
Physical Health

Moderator:	A. Kent Waldrep, Jr.
Presenter:	Dr. Anita Leal
Panelist:	William Murrain Janet Foster
Recorder:	Dr. Anita Hall
Major Focus:	Physical Health

Dr. Anita Leal's presentation in this area was titled Minorities, Physical Health, and Disability. Her paper cited the assumption that disability is not fully a part of the debate on the need for better health care for minorities. It was also revealed that disability as a health and social issue, gets minimal attention from the epidemiological community. And, the disability community neglects minorities in its policy planning.

The focus question used by the presenter included: What do we know about physical health of minorities? What do we know about physical health of minorities with disabilities?, and, Is the disability process the same with minorities and non-minorities? Using these questions as a base the presenter established a framework for determining what is the disability process.

The framework schema identified:

PATHOLOGY (The illness) /IMPAIRMENT/ FUNCTIONAL LIMITATION/ DISABILITY

The "survivor effect" is an inclusion of the schema that may explain the disability projection of minorities. The disability projection seems to occur between the areas of functional limitation and disability. It appears that many minorities survive beyond the projection in their health status and become disabled.

The presentation contained a great deal of data which was gathered from three major sources.

Major Reports Used

Report of the Secretary's Task Force on Black and Minority Health (1985), which focuses on six health problems that accounted for over 80% of deaths among minorities: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents, and infant mortality.

Health Status of Minorities and Low-Income Groups (1991) compiled by the Health Resources and Services Administration characterizes the lack of parity as an inequity between the disadvantaged and advantaged elements of the U.S. society.

Disability in America which focuses on "prevention of potentially disabling conditions from developing into disability and on minimizing the effects of such conditions on a person's productivity and quality of life."

Identified Minority Groups

The paper focused upon four major groups Blacks (Afro-American); Asian/Pacific Islanders, Native American and Hispanics (Latino).

Determinants of Disability

Dr. Leal reported that the data sources often omits specific identification of minorities in listing information. This is particularly true of minority groups other than Afro-American. The data on morbidity (the rate of disease) and mortality (rate of death) seems to be combined in reporting the health status of minorities or this information is extrapolated from other sources.

The major risk factor that affects the health status of minorities included smoking, high cholesterol, elevated blood pressure, and obesity.

Health Status and Types of Diseases/Disabilities

The discussion included the identification of racial groups and the prevalence of work limitation by race and ethnicity. Data was also shared that reported the health status of Afro-Americans and Whites in the categories of fair or poor health; good to excellent health, limited in activity and not limited in activity.

Orthopedic impairment, mental illness, mental retardation, substance abuse, hearing impairments, visual impairments, learning disabilities, heart/circulatory and absence of limbs were major disabilities for which data was reported by race and ethnicity.

Access to Health Care

Dr. Leal's paper also stated that the six leading causes of death among minority persons were preventable. She indicates that in order to prevent diseases and disability, an encounter with a health system is necessary. Additionally it was discussed that often persons within the minority community may not be served as aggressively by medical professionals from the majority community.

This paper indicates four possible barriers to accessibility to health care: (1) high cost of medical care; (2) lack of insurance coverage; (3) poorly located service sites and lack of minority providers of care; and (4) reduced funding for state and federal programs.

Recommendations

The recommendations included the need for an informed public health policy with a focus on obtaining consistent information of the health status of minority person, including those with disabilities. A need to standardize terms and compile a database. The need for a special public health policy on the needs of minority persons with disabilities. A need to improve collection of information on the incidence and prevalence of disability research into the most effective points on intervention and reduction of the barriers to health care.

Panel Response

Janet Foster and Bill Murrain discussed the paper presented by Dr. Leal. Foster found the data overwhelming and stated some major concerns - the lack of comparative data and who's compiling the data?, and, Were the correct questions asked in soliciting information from the respondents? Foster also stated that the described phenomenon regarding survival was striking and haughty. That is, Leal reported that..."After age 65, the gap in life expectancy between Blacks and Whites actually appears to close"... This haughtiness is often reflected about the Afro-American female... the strong Black woman syndrome.

Foster's focus on the accessibility of health care seemingly brought a great deal of reality to the discussion. She stated that accessibility to health care is wide open for two major groups ----THE IMPREGNATED AND THE INCARCERATED, children under the age of five may also have greater accessibility to health care.

Our system does not provide accessibility for healthy children and young adults - particularly preventive medical care. Persons between the ages of 12 to 30 have the greatest exposure to life threatening diseases or trauma. This factor is reflected in the high insurance premiums for auto drivers under the age of 25.

The approach to better physical health and long range goals for minorities is through educating our youth according to Foster. We must stress wholesome life styles and it must become the responsibility of the minority community to be advocates to living well.

Bill Murrain reflected upon the six major diseases described by Dr. Leal and observed that each is behavioral induced. He stated that the increase in violence as a contributing factor in the area of disability is now so pervasive that the Center for Disease Control is examining it in the area of major health risk.

Murrain was also concerned about how the data was arrived at and the lack of

identification of the sample pool from which the statistics may have been drawn. He stated that a report that he recently reviewed stated that 15% of the "Crack Cocaine" babies were born to Whites and 85% to minorities and others. His question was: Who and what groups were represented in the 85% pool?

Murrain reminded the group that policy is data driven -- NO POLICY is developed without data which often results in FAULTY POLICIES. He recommended that the National Council on Disability create a minority advisory committee to address and keep in the forefront specific questions related to minorities with disabilities. The advisory committee could continually report to the Executive Director the needs and concerns of the minority community.

Concurrent Workshop
Session III
Education

Moderator:	Dr. Franklin D. Jefferson
Presenter:	Dr. Frederick D. Bedell
Panelists:	Dr. Bruce Ramirez Dr. Tennyson J. Wright Dr. Julian Castillo
Recorder:	Dr. William Rush
Major Focus:	Education

The presenter demonstrated an in depth knowledge of his subject. His research was very well synthesized and presented. The panel members gave a detailed review of the presenter's research and were able to relate aspects of their own research to the content of the presentation.

Following are a few of the primary points that were made by the presenter:

1. Ability grouping should be abolished. Such grouping increases the student's feeling of low-self concept and isolation

2. Cooperative learning should be emphasized. Students learn from each other and they need to feel that they can function with their peers.

3. Individual learning plans should be emphasized. The uniqueness of the student with a disability is necessary to provide a plan of learning for him/her that will be more conductive to his/her needs.

4. More effort should be given to plans and programs to bring students to school ready to learn. The student with a disability is very much aware of his/her shortcomings. This awareness does not need to be increased by a lack of preparation.

5. Collaborative work with the student with a disability should be emphasized. Effort from the total community is needed if these

students are to fully develop their potential.

The following are comments made by the panelists:

1. More emphases should be placed on the learner's needs.

2. More consideration should be given to diversities that are found among students with disabilities.

3. More attention should be given to solving the problems of racism and sexism.

4. A lack of adequate insurance is a major problem.

5. Our society tends to blame the poor and disabled for their conditions.

6. More attention should be given to the rapid growth of disabilities that can be found within certain ethnic groups. Emphases were placed on the Hispanics.

Concurrent Workshop
General Session

Moderator:	Maggie Wade
Presenters:	Dr. Tennyson Wright Janet Foster Dr. Henry Lewis Ruth Royall Hill Claudie Grant Delores Watkins
Recorder:	Mrs. Rosalind Thomas
Major Focus:	Minorities with Disabilities

The session began with an invocation by Dr. Richard Middleton and greetings from Larry Brown, Jr., Dr. Everette Witherspoon, Dr. E.C. Forster, Dr. Yvonne Brooks, Dr.Carolyn Black and Mr. Albert J. Couthen. Television commentary for the panel discussion on Emerging Issues was Maggie Wade, WLBT Channel 3. A brief summary of the presentations are as follows:

1. Dr. Tennyson Wright expressed concerns on the issues of the '90s' (ethnic minorities) which include:

   A. Research

   B. Re-education of educators

   C. Updated accreditation of educational programs to train persons to work with minorities with disabilities

2. Dr. Janet Foster spoke from the parental standpoint on help for parents with children who have disabilities.

3. Ruth Royal Hill spoke extemporaneously on the following areas:

   A. Mental deficiencies

   B. Substance abuse

   C. Public school mix

1. Cognitive

2. Team efforts

3. Creativities

D. Lack of organization for minorities with disabilities

E. Teaching leadership, assessing and the training

F. Marketing the program

4. Dr. Tim Summers shared insights on the rising problems of

A. Racism

B. Money vs. volunteerism

C. Lack of leadership

D. Lack of church involvement

E. Recognizing PEOPLE, as one of our greatest resources

5. Claudie Grant expressed personal experiences about the National Urban Leagues's lack of production with minorities. He noticed the prejudice among sisters and brothers and listed problems among races including:

A. Hispanic-speaking problems

B. Black American language deficiency and lack of money

C. 82% of Black Americans with disabilities are unemployed

6. Delores Watkins gave a statistical overview of the status of the disabled which included:

A. There are 33 million disabled Americans

B. There will be 42 million Americans with disabilities by the year 2000

C. There will be 47 million Americans with disabilities by the year 2020

D. 20 million are work disabled. She admonished the rehabilitation community to:

1. Increase research on disabilities

2. Review funding priorities (do they speak to minorities?)

3. Increase support for each other

At the end of the panel discussion Ms. Wade opened the floor to a brief question/answer period. Questions included:

Q. No one really helped me when I needed help. What should I do?

A. Find another parent with a disabled child and share/seek information, ask for a case manager, locate referral of services, ask for a family physician (Dr. Summers)

Q. Why are people misdiagnosed/misplaced?

A. Eurocentric Model (Placement Model) looks at what the person does not have as opposed to what they do have. Need development appropriate norms for all people. Write letters to prioritize multicultural issues.

Q. What is NIDRR doing to assure they are hearing from whom they need to hear from?

CONFERENCE PROGRAM

NATIONAL COUNCIL ON DISABILITY
and
JACKSON STATE UNIVERSITY
present

"The Unique Needs of Minorities with Disabilities: Setting An Agenda For the Future"
Jackson, Mississippi
May 6-7, 1992

Wednesday, May 6, 1992

8:00 a.m.	BUS DEPARTS HOTEL TO UNIVERSITY
8:00 a.m. - 5:00 p.m.	REGISTRATION GENERAL PURPOSE ROOM
8:30 a.m. - 9:00 a.m.	CONTINENTAL BREAKFAST
9:00 a.m. - 10:15 a.m.	OPENING GENERAL SESSION
PRESIDING	Dr. Glenda Winfield Assistant Professor Department of Special Education and Rehabilitative Services Jackson State University
INVOCATION	Fr. Richard Chiles Pastor Christ The King Catholic Church Jackson, MS
WELCOMING REMARKS	Mary Ann Mobley Collins Member National Council on Disability Washington, DC

Dr. Celestine R. Jefferson
Chairperson
Department of Special Education and
Rehabilitative Services
Jackson State University

GREETINGS

Governor Kirk Fordice
State of Mississippi

Dr. Herman Smith
Interim President
Jackson State University

Sandra Swift Parrino
Chairperson
National Council on Disability
Washington, DC

Message from President George Bush

John Calhoun
Community Coordinator
The Office of the Mayor
Jackson, MS

Dr. Johnnie R. Mills-Jones
Dean
School of Education
Jackson State University

JACKSON STATE UNIVERSITY CHOIR

"Sing A New Song" by Robert Kreutz

"Precious Lord" by Dorsey:
Arranged by Arnold Sevier

Dr.. Robert L. Morris
Director
Jackson State University Choir

Arnold Sevier
Pianist
Jackson State University

INTRODUCTION OF SPEAKER	Dr. Johnnie R. Mills-Jones Dean School of Education Jackson State University
SPEAKER	Carl Boyd, Author/Lecturer "NOBODY RISES TO LOW EXPECTATIONS"
RECOGNITION OF SPEAKER	Mary Ann Mobley Collins Member National Council on Disability Washington, DC
CONFERENCE LOGISTICS	Dr. Frederick D. Bedell Conference Coordinator President Del--K Educational Consultancy Services Albany, NY
CLOSING REMARKS	Dr. Everette Witherspoon Vice-President Academic Affairs Jackson State University
10:20 a.m. - 10:30 a.m.	BREAK
10:30 a.m. - 12:00 Noon	CONCURRENT WORKSHOPS - SESSION I
A. EMPLOYMENT	Faculty Lounge
Moderator	Dr. George Oberle Member National Council on Disability Washington, DC
Presenter	Ms. Alyce Jenkins Associate Professor Rehabilitation Services Wright State University Dayton, OH
Panelists	Claudie Grant, Jr. Employment Advisor President's Committee on Employment of People with Disabilities Washington, DC

235

Loran Graham
Handicapper Program Manager
Department of Civil Service
Lansing, MI

Dr. Daniel Wong
Associate Professor
San Jose State University

Recorders

Dr. Louise Jones
Acting Chairperson
Department of Education Foundations
and Leadership
Jackson State University

Ms. LaWanda Smith-Cline, Teacher
Hazelhurst Elementary School
Jackson, MS

B. RESEARCH NEEDS OF MINORITIES WITH DISABILITIES

Student Lounge

Moderator

John A. Gannon
Member
National Council on Disability
Washington, DC

Presenter

Dr. Paul Leung
Director
Division of Rehabilitation
Education Services
University of Illinois at Urbana-Champaign

Panelists

Dr. Jean Farish
Assistant Professor
Department of Special Education and
Rehabilitative Services
Jackson State University

Sylvia Walker
Howard University
Research and Training Center
Washington, DC

C. MENTAL HEALTH	Jacksonian Lounge
Moderator	Anthony H. Flack Member National Council on Disability Washington, DC
Presenter	Dr. Timothy Summers Psychiatrist Jackson, MS
Panelists	Henry Williams Director Intensive Case Management Bronx Psychiatric Center Bronx, NY
	Dr. Lynda Katz Project Director Western Psychiatric Institute and Clinic University of Pittsburgh
	Dr. Doreen Miller Associate Professor Department of Psychology and Rehabilitation Counseling Services Southern University
Recorders	Dr. Sherry Briggs Associate Professor Department of Special Education and Rehabilitation Services Jackson State University
	Ms. Velma J. Bingham Senior, Elementary Education Jackson State University
12:15 p.m . - 2:00 p.m.	LUNCHEON - General Purpose Room
Presiding	Dr. Hill Williams Assistant Professor Health, Physical Education and Recreation Jackson State University

INVOCATION	Dr. Ivory Phillips Professor Department of Curriculum and Instruction Jackson State University
OPENING REMARKS	John A. Gannon Member National Council on Disability Washington, DC
	LUNCH
INTRODUCTION OF SPEAKER	Larry Brown, Jr. Member National Council on Disability Washington, DC
SPEAKER	John R. Dunne Assistant Attorney General Civil Rights Division U.S. Department of Justice Washington, DC
RECOGNITION OF SPEAKER	Larry Brown, Jr. Member National Council on Disability Washington, DC
CLOSING REMARKS	Dr. Mariam Talley Director Graduate Program School of Education Jackson State University
2:00 p.m. - 3:30 p.m.	WORKSHOPS SESSION II
Moderator	Dr. George H. Oberle Member National Council on Disability Washington, DC
Presenter	Dr. Frank Giles Director Rehabilitation Counseling Program Jackson State University

Panelists	Dr. Madan Kundu Director Rehabilitation Counseling Program Southern University
	Dr. Eddie Glenn Professor Rehabilitation Counseling South Carolina State College
	Dr. William Talley Director Rehabilitation Program University of Maryland-ES
Recorder	Dr. Gloria Dansby-Giles Assistant Professor Department of Counseling and Human Resource Education Jackson State University

B. PREVENTION OF PRIMARY AND SECONDARY DISABILITIES

Panoletic Lounge

Moderator	A. Kent Waldrep Vice Chairperson National Council on Disability Washington, DC
Presenter	Julie A. Clay Project Manager Prevention of Secondary Disability Montana University Affiliated Rural Institute on Disabilities University of Montana
Panelists	Katherine Williams Chief Office of Disability Consumer and Regulatory Affairs Washington, DC

	Larry Burt Director Disabilities Prevention Program Centers for Disease Control Atlanta, GA
Recorder	Dr. Leroy Kemp Professor Department of Curriculum and Instruction Jackson State University
C. EMPOWERMENT	Jacksonian Lounge
Moderator	Dr. Ivory Phillips Professor of Social Science Education and Geography Jackson State University
Presenter	Eva Britt Attorney Information and Protection Advocacy Center for Handicapped Individuals Washington, DC
Panelists	Cheryl Wu Coordinator Hearing Impaired Program Big Brothers, Big Sisters San Francisco, CA
	Kaye Gainer ADA Consultant Association of Retarded Citizens Atlanta, GA
Recorder	Dr. ReJohna Brown Professor Department of Curriculum and Instruction Jackson State University
3:35 p.m. - 3:45 p.m.	BREAK
3:45 p.m. - 5:15 p.m.	CONCURRENT WORKSHOPS SESSION III

A. PHYSICAL HEALTH	Panoletic Lounge
Moderator	A. Kent Waldrep Vice Chairperson National Council on Disability Washington, DC
Presenter	Dr. Anita Leal Director Employee Support Program University of California Santa Cruz, CA
Panelists	William Murrain Program Specialist Minority Health Centers for Disease Control Atlanta, GA
	Janet Foster Program Director New York State Department of Health
Recorder	Dr. Anita Hall Chairperson Department of Curriculum and Instruction Jackson State University
B. SUBSTANCE ABUSE	Faculty Lounge
Moderator	Dr. Louise Jones Acting Chairperson Department of Education Foundation and Leadership Jackson State University
Presenter	Dr. James Brown Psychologist Florida Department of Labor and Employment Security, Division of Vocational Rehabilitation Tallahassee, Florida
Panelists	Milagros V. McGuire Supervisor Hispanic and Special Populations Program Rehabilitation Services Washington, DC

Dr. Edward Smith
Assistant Professor
Rehabilitation Counselor
Education Programs
University of Wisconsin

John Smith
Project Director
Office of Health Promotion
Morehouse School of Medicine

Dr. Evelyn Davis
Assistant Clinical
Professor of Pediatrics
Behavioral and Developmental
Pediatrician
Harlem Hospital Center
Columbia University
New York, NY

Recorders

Dr. Richard T. Middleton III
Director of Student Teaching and
Field Services
Jackson State University

Ms. Dorothy Fort
Teacher
Canton High School
Jackson, MS

C. EDUCATION — Jacksonian Lounge

Moderator

Dr. Franklin D. Jefferson
Associate Professor
Department of Curriculum and
Instruction
Jackson State University

Presenter

Dr. Frederick D. Bedell
President, Del-K Educational
Consultancy Services
Albany, NY

Panelists	Dr. Bruce Ramirez Special Assistant Ethnic and Multicultural Concern Council for Exceptional Children Washington, DC
	Dr. Tennyson J. Wright Assistant Provost University of South Florida Tampa, FL
	Dr. Julian Castillo Professor Division of Health Related Professions University of Texas Edinburg, TX
Recorder	Dr. William Rush Assistant to the Dean School of Education Jackson State University
5:45 p.m. - 7:30 p.m.	RECEPTION Hosted by Department of Special Education and Rehabilitative Services Jackson State University
HOSTESS	Ms. Debra Lee, Senior Special Education Major Jackson State University
SPECIAL GUEST	Mrs. Margie Funches 1992 Retiree (42 yrs.) Department of Special Education and Rehabilitation Services Jackson State University
7:45 p.m.	BUS RETURNS TO HOTEL

Thursday, May 7, 1992

8:00 a.m.	BUS DEPARTS FOR UNIVERSITY
8:30 a.m. - 9:00 a.m.	Continental Breakfast
9:00 a.m. - 12:00 noon	SECOND GENERAL SESSION

	General Purpose Room
PRESIDING	Dr. Melvin Evans Chairman Department of Health Physical Education and Recreation Jackson State University
INVOCATION	Dr. Richard T. Middleton III Postulant St. Mark's Episcopal Church Jackson, MS
GREETINGS	Larry Brown, Jr. Member National Council on Disability Washington, DC
	Dr. Everette Witherspoon Vice President for Academic Affairs Jackson State University
	Dr. E. C. Foster President, City Council Jackson, MS
	Dr. Yvonne Brooks Assistant Superintendent Exceptional Education Jackson Public Schools
	Dr. Carolyn Black Bureau of Special Services State Department of Special Education Jackson, MS
	Mr. Albert J. Couthen Attendance Center Principal Mississippi School for the Deaf Jackson, MS
PANEL DISCUSSION	EMERGING ISSUES
	General Purpose Room

Moderator	Maggie Wade WBLT- Channel 3 Television Commentator Jackson, MS
Presenters	
Education	Dr. Tennyson Wright Assistant Provost University of South Florida Tampa, FL
Health	Janet Foster Program Director New York State Department of Health
	Dr. Henry Lewis Dean College of Pharmacy and Health Services Texas Southern University
Rehabilitation	Ruth Royal Hill Administrator Rehabilitation Services Administration Washington, DC
Employment	Claudie Grant Employment Advisor President's Committee on Employment of People with Disabilities Washington, DC
Research	Delores Watkins Program Specialist National Institute on Disability and Rehabilitation Research Washington, DC
Recorders	Dr. T. Lee Napier Professor Department of Administration and Supervision Jackson State University
	Ms. Lois Ann Pearce Teacher Brandon Elementary School Jackson, MS

	Ms. Rosaline Thomas Teacher Clausell Elementary School Jackson, MS
12:00 p.m. - 3:00 p.m.	LUNCHEON AND CLOSING SESSION
	General Purpose Room
PRESIDING	Dr. Vivian Taylor Associate Professor Department of Curriculum and Instruction Jackson State University
INVOCATION	Dr. Mariam Talley Professor Graduate Programs School of Education Jackson State University
OPENING REMARKS	Dr. Celestine R. Jefferson Chairperson Department of Special Education and Rehabilitative Services Jackson State University
INTRODUCTION OF SPEAKER	Ms. Patty Jo Spiek, Sophomore Elementary Education Jackson State University
SPEAKER	Dr. Ruby Wiggins Associate Professor Department of Special Education and Rehabilitative Services
COMMENTS	Representatives from Jackson State Student Body
	Mrs. Elizabeth Stewart Graduate Student Department of Educational Foundations and Leadership
	Mrs. Patty Jo Spiek, Sophomore Elementary Education

Mrs. Clyde Speaks
Senior
Special Education and
Rehabilitation Services

Mrs. Beth Jeter
Senior
Health, Physical Education and
Recreation

Mr. Eric D. Williams
Junior
Elementary Education

Ms. Gloria Wynn
Graduate
Department of Counseling and Human
Resources Education

Ms. Debra Lee
Senior
Special Education and
Rehabilitative Services

Ms. Bettie Martin
Junior
Elementary Education

RECOGNITION OF SPEAKER

John A. Gannon
Member
National Council on Disability
Washington, DC

REPORTS FROM WORKSHOPS

Employment
Recorder: Dr. Louise Jones

Research
Recorder: Dr. Earl Leggette

Mental Health
Recorder: Dr. Sherry Briggs

Rehabilitation
Recorder: Dr. Gloria Giles

Prevention
Recorder: Dr. Leroy Kemp

Empowerment
Recorder: Dr. ReJohna Brown

Physical Health
Recorder: Dr. Anita Hall

Substance Abuse
Recorder: Dr. Franklin Jefferson

Panel Discussion
Recorder: Dr. T. Lee Napier

THE NEXT STEPS

Larry Brown, Jr.
Member
National Council on Disability
Washington, DC

CLOSING REMARKS

Sandra Swift Parrino, Chairperson
National Council on Disability
Washington, DC

PARTICIPANTS

National Council on Disability/Jackson State University
The Unique Needs of Minorities with Disabilities: Setting An Agenda For The Future
Jackson, Mississippi
May 6-7, 1992

PARTICIPANTS LIST

Sandra Swift Parrino
Chairperson, National
Council on Disability
Washington, DC

Mary Ann Mobley Collins
Member, National Council
on Disability
Washington, DC

Larry Brown
Xerox Corporation
Member, National Council on
Disability, Washington, DC

John Calhoun
Community Coordinator
Office of the Mayor
Jackson, MS

John Gannon
Member
National Council on Disability
Washington, DC

Dr. Richard Chiles, Pastor
Christ The King Catholic Church
Jackson, MS

Governor Kirk Fordice
State of Mississippi

Dr. Herman Smith, Interim
President, Jackson State
University
Jackson, MS

Dr. Everette Witherspoon, Vice-
President for Academic Affairs
Jackson State University
Jackson, MS

Anthony Flack
Member
National Council on Disability
Washington, DC

Dr. Glenda Winfield
Assistant Professor
Department of Special Education
and Rehabilitative Services
Jackson State University
Jackson, MS

Dr. Celestine Russell Jefferson
Chair, Department of Special
Education and Rehabilitative
Services
Jackson State University
Jackson, MS

Dr. Johnnie R. Mills-Jones, Dean
School of Education
Jackson State University
Jackson, MS

Dr. Frederick D. Bedell
President
Del-K Educational Services
Albany, New York

A. Kent Waldrep
Member
National Council on Disability
Washington, DC

Claudie Grant, Employer Advisor
President's Committee on
Employment of Peoples with Disabilities
Washington, DC

Dr. Louise Jones, Acting Chair
Department of Education
Foundations and Leadership
Jackson State University
Jackson, MS

Dr. Sylvia Walker
Director
Research and Training Center
Washington, DC

Ethel Briggs
Executive Director
National Council on Disability
Washington, DC

Dr. Ivory Phillips, Professor
Department of Cuurriculum and
Instruction
Jackson State University

Dr. George Oberle, Member
National Council on Disability
Washington, DC

Carl R. Boyd
Author-Lecturer
Kansas City, MO

Dr. Franklin D. Jefferson
Associate Professor
Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

Loran Graham
Program Manager
Department of Civil Service
Lansinng, MI

Dr. Jean Farish, Assistant
Professor, Department of Special
Education and Rehabilitative
Services, Jacksosn State University
Jackson, MS

Dr. Gladys Johnson, Professor
Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

Dr. Vivian Taylor, Associate
Profesor, Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

John Dunne, Assistant Attorney
General, Civil Rights Division
Department of Justice
Washington, DC

Dr. Sherry Briggs, Associate
Professor, Department of
Special Education and
Rehabilitative Services
Jackson State University
Jackson, MS

Dr. Frank Giles, Director
Rehabilitation Counseling Program
Jackson State University
Jackson, MS

Dr. Gloria Giles, Assistant
Professor, Department of Counseling
and Human Resource Education
Jackson State University
Jackson, MS

Dr. Leroy Kemp, Professor
Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

William Murrian, J.D.
Program Specialist
Minority Health
Centers for Disease Control
Atlanta, GA

Dr. Anita Hall, Chair
Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

Dr. Richard T. Middleton, III
Director of Student Training
and Field Services
Jackson State University
Jackson, MS

Dr. Daniel Wong
Associate Professor
San Jose State University
San Jose, CA

Mrs. Margie Funches (Retiree)
Department of Special Education
and Rehabilitative Services
Jackson State University
Jackson, MS

Dr. E.C. Foster, President,
City Council
Jackson, MS

Dr. Yvonne Brooks, Assistant
Superintendent, Exceptional
Education, Jackson Public Schools
Jackson, MS

Dr. Carolyn Black, Bureau of
Special Services, State Department
of Special Education
Jackson, MS

Mr. Albert J. Couthen, Attendance
Center, Principal
Mississippi School for the Deaf
Jackson, MS

Maggie Wade
WBLT -- Channel 3
Television Commentator
Jackson, MS

Janet Foster, Program Director
New York State
Department of Health
Albany, NY

Dr. T. Lee Napier, President
Department of Administration
and Supervision
Jackson State University
Jackson, MS

Dr. William Rush, Assistant
To the Dean, School of Education
Jackson State University
Jackson, MS

Dr. Effie Clay, Associate Professor
Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

Dr. James Brown, Psychologist
Florida Department of Labor and
Employment Security, Division of
Vocational Rehabilitation
Tallahassee, FL

Dr. Paul Leung, Director, Division
of Rehabilitatiion Education
Services, University of Illinois-Urbana
Champaign, IL

Eva Britt, Attorney, Information
Protection and Advocacy Center
for Handicapped Individuals
Washington, DC

Julie Clay, Project Director
Prevention of Secondary Disabilities
Montana University Affliates
Rural Institute on Disabilities
University of Montana
Missoura, MT

Ruth Royal Hill
Administrator,
Rehabilitation Services Administration
Washington, DC

Dr. Eddie Glenn
Assistant Professor
Rehabilitataion Counseling Program
South Carolina State College
Orangeburg, SC

Dr. ReJohnna Brown, Professor
Department of Curriculum
and Instruction
Jackson State University
Jackson, MS

Dr. Mariam Talley, Director
Graduate Programs
School of Education
Jackson State University
Jackson, MS

Dr. Anita Leal, Director
Employee Support Programs
University of California-Santa Cruz
Santa Cruz, CA

Dr. Tennyson J. Wright
Assistant Provost, Academic Affairs
University of South Florida
Tampa, FL

Ms. Alyce Jenkins, Associate Professor
Wright State University
College of Education and
Human Services
Dayton, OH

Dr. Timothy Summers, M.D.
Jackson, MS

Evelyn Davis, M.D.
Assistant Professor of Pediatrics
Pediatrician, Harlem Hospital Center
Professsor, Columbia University
New York, NY

Cheryl Wu
Coordinator
Hearing Impaired Program
Big Brothers/Big Sisters
San Francisco, CA

Dr. Linda Katz
Projector Director
Westen Psychiatric
Institute and Clinic
University of Pittsburgh
Pittsburgh, PA

Henry Williams
Director
Intensive Case Management
Bronx Psychiatric Cennter
Bronx, NY

Katherine Williams
Chief
Office of Disability Affairs
Consumer and Regulatory Affairs
Washington, DC

Dr. Doreen Miller
Associate Professor
Department of Psychology and
Rehabilitation Counseling Services
Southern University
Baton Rouge, LA

Dr. Madan Kundu
Director
Rehabilitation Counseling Program
Southern University
Baton Rouge, LA

Dr. Julian Castillo
Professor
Division of Health Related Professions
University of Texas
Edinberg, TX

Ms. Lawanda Smith Cline
Teacher
Hazelhurst Elementary School
Jackson, MS

Dr. William Talley
Director
Rehabilitation Programs
University of Maryland E-S
Princess Anne, MD

Dr. Hill Williams
Director
Assistant Professor
Health, Physical Education and Recreation
Jackson State University
Jackson, MS

Kaye Gainer
ADA Consultant
Association of Retarded Citizens
Atlanta, Ga

Milagros V. McGuire
Supervisor
Hispanic and Special Populations
Program, Rehabilitation Services
Administration
Washington, DC

John Smith
Project Director
Office of Health Promotion
Morehouse College School of
Medicine
Atlanta, GA

Dr. Bruce Ramirez
Special Assistant
Ethnic and Multicultural Concerns
Council For Exceptional Children
Reston, VA

Ms. Dorothy Fort
Teacher
Canton High School
Jackson, MS

Delores Watkins
Program Specialist
National Institute on Disability
and Rehabilitation Research
Washington, DC

Ms. Lois Ann Pearce
Teacher
Brandon Elementary School
Jackson, MS

Dr. Ruby Wiggins
Associate Professor
Department of Special Education
and Rehabilitative Services
Jackson State University
Jackson, MS

John Moore
Des Hinds County Schools
Raymond, MS

Lareta Thomas
Elder Abuse SW/Ombudsman
LSWCMPDD/Area Agency on Aging
Jackson, MS

Angela Giuhan
Case Manager
Area Agency on Aging
Jackson, MS

Kevin Kimble, Student
Jackson State University
Wesson, MS

Pamela K. Johnson, Student
Jackson State University
Jakcson, MS

Pauline Heard-Dunn
Special Ed. Teacher
Mississippi School for the Deaf
Jackson, MS.

Len Jefferson, MPA
Jackson State University
Jackson, MS

A. Prook
Dept. of Counseling & Human Resource Ed.
Jackson State University
Jackson, MS

Loria H. Powell
Counselor
Jackson, MS

P. T. Banlanta
Jackson, MS

Virginia D. Gambrell
Director TEI
Tougaloo College
Tougaloo, MS

Rosalind F. Thomas, Teacher
Clausell Elementary School
Jackson, MS

Gary W. Olsen, Supt.
MS School for the Deaf
Jackson, MS

Mary Stallworth, Teacher
Hazelhurst Elementary School
Jackson, MS

Edna Duncan, Consultant
Mississippi Dept. of Education
Jackson, MS

Suzy Baines, Counselor
Addie McBryde Center
Jackson, MS

Emma Crawford, Graduate
MSH Vocational Rehabilitation
Whitfield, MS

Grady Gilkey III
Interpreter for the Deaf
Mississippi School for the Deaf
Jackson, MS

John Calvin, Regional Director
Office of Vocational Rehabilitation
Tupelo, MS

Gloria Wynn, Graduate Student
Jackson State University
Jackson, MS

Delores Mack, Teacher
MS School for the Deaf
Jackson State University
Jackson, MS

Zehma Mogee, Student
Jackson State University
Jackson, MS

Nancy Cline, Director
of Supported Employment
Hudspeth Retardation Center
Whitfield, MS

Adele Crudden, Director
Addie McBryde Rehab. Ctr. for the Blind
Jackson, MS

Sherry Hughes, Counselor
Vocational Rehabilitation
McComb, MS

Sylvia Bailey, Social Worker
MCFS
Rolling Fork, MS

Gus Bowering, Consultant
Mississippi Dept. of Education
Jackson, MS

Lillie Henry
Independent Living Trainer
Rolling Fork, MS

Parigan Mihall, Graduate Student
Jackson State University
Jackson, MS

Sharon Bridges, Teacher
MSD, Jackson State University
Jackson, MS

Robin Manning, Teacher
The Education Center
Jackson, MS

Lois Anne Pearce, Teacher
Brandon Elementary School
Brandon, MS

Chrystele McKandes
Jackson State University
Jackson, MS

Cynthia Huff
Division of Disabilities Prevention
Jackson, MS

George Graves, Mgr. - W. A. C.
Gulf Coast Mental Health Center
Gulfport, MS

M. Janice Stewart, Supervisor
Vocational Rehabilitation
McComb, MS

Mrs. Lloyd
Jackson, MS

James Clayton, Counselor I
Jackson, MS

Jennette Collier, Assst. Director
Food Services
Jackson, MS

Therese Amadi, Student
Jackson State University
Jackson, MS

Helen Bush, MCFS
Rolling Fork, MS

Gwen Webster, ADOM/MS-PAC
Jackson, MS

Pearl M. Vincent
Jackson State University
Jackson, MS

Mark Quigley
National Council on Disability
Washington, DC

Anne Presley, Director
Mississippi Parent Advocacy Center
Jackson, MS

Shirley Carpenter, Secretary
Jackson State Universitiy
Jackson, MS

Georgia Foster, Stock Clerk
Jackson State University
Jackson, MS

Elsie Roard, Graduate Student
Jackson State University
Jackson, MS

Sheila Ashley
Magnolia, MS

T.K. Bridges, Supervisor
Huntsville, AL

Brenda Bratton
National Council on Disability
Washington, DC

Odium Okidike, WETP
Jackson, MS

Gloria Rhodes, MCFS
Rolling Fork, MS

Robert Green, Foreman of Carpentry
Jackson State University
Jackson, MS

Anthony Hard
National Council on Disability
Washington, DC

Shirley Brown, Area Supervisor
Vocational Rehabilitation
Jackson, MS

Tracye Page
Jackson State University
Jackson, MS

Irene Pittman
Jackson State University
Jackson, MS

Stephania M. Boyd, Student
Jackson State University
Jackson, MS

Marcina Alexander
Jackson, MS

Karen Holmer, Area Supervisor
Vocational Rehabilitation
Oxford, MS

Rannie Lewis, Ph.D.
Associate Professor
Jackson State University
Jackson, MS

M. Eckman, Special Ed. Teacher
Jackson, MS

Ursula Thompson, Spec. Prog. Off.
Governor's Office
Governor's Office
State of Mississippi

Pat Harris
Job Development Coordinator
Voc. Rehab. for the Blind
Jackson, MS

Phoebe Moffett, Student
Jackson State University
Jackson, MS

Jeffie White, Area Supervisor
Vocational Rehabilitation Services
Jackson, MS

Motice Bruce-Decr
DECPLOMBE
Jackson, MS

Dextra Tover
Governor's Office
State of Mississippi

Ruby Collins, SLDF Teacher
Nichols Middle School
Canton, MS

Billy A. Roby
Director, Campus View
Jackson State University
Jackson, MS

Billie Jean Hill, Program Specialist
National Council on Disability
Washington, DC

Dr. Edward R. Smith
Assistant Professor
Univ. of Wisconsin at Milwaukee
Milwaukee, WI

Sandra Taylor
Resource Ctr. Coordinator
Jackson State Universitiy
Jackson, MS

Janet Mize
Research Associate
ITD
Oxford, MS

B. Janilyn Weld
Deaf Service Center
Jackson, MS

Dolly M. E. Robinson
Jackson State Universiity
Jackson, MS

Leslie Sivilley
Whitfield, MS

Gwendolyn Stokes
Rehab. Counselor
Jackson, MS

Mary Raether
National Council on Disability
McLean, VA

Linda B. Whitehead
Selective Placement Mgr.
USDA, SCS
Jackson, MS

Tara W. Evans
Concerned Parent
Willowood Advisory Board
Jackson, MS

Jim Myrick
Boswell Retardation Center
Sanatorium, MS

Eddie Givens, Area Supervisor
Vocation Rehabilitation
Hazlehurst, MS

Selena Nichols Horne
Jackson, MS

William Rush, Asst. Dean
Jackson State University
Jackson, MS

Virginia Gambrell
Tougalo College

Michael W. Sweat
Supported Employment, Job Coach
Hudspeth Center
Whitfield, MS

Lila McEllroy, Teacher
Nichols Middle School
Canton, MS

Louise Jones, Faculty
Jackson State University
Jackson, MS

Faye Booth
Supported Employment, Job Coach
Hudspeth Center
Whitfield, MS

John D. Mitchell
Supported Employment
Person Futures Planner
Hudspeth Center
Whitfield, MS

Laurie Reece
Social Worker
Hudspeth Center
Whitfield, MS

Jeruthie Lockett, Program Coordinaor
MS Protection & Advocacy
Jackson, MS

Joyce Adair, Program Evaluator
Dept. of Mental Health IMR
Jackson, MS

Armelia N. Porter, Beautician
Canton, MS

Anne Seggerman
National Council on Disability
Fairfeild, CT

Dorothy Fort, Teacher
Jackson, MS

Panganeeha R. Mihell
Graduate Rehab. Student
Jackson State University
Jackson, MS

David Sanders
Boswell Retard. Center
Jackson, MS

Emma Crawford, Graduate Student
Jackson State Universiity
Jackson, MS

Mike Dotteray
Northwest MS Community College

Mattey S. Wilson
Special Education
Jackson State University
Jackson, MS

Patricia Jordan
Director of Exceptional SVCS.
Canton Public Schools
Canton, MS

Leroy Kemp
Jackson State University
Jackson, MS

Ruben Gentry
Jackson State University
Jackson, MS

Ada Nelson
Jackson, MS

Terry B. Rasi
Tchula, MS

Sylvia Stevens, Counselor
Jackson Ctr. for Independent Living
Jackson, MS

Shirley Williams, Teacher
MS School for the Deaf
Jackson, MS

Bennie Owens Jr.
Jackson Ctr. for Independent Living
Jackson, MS

Carol Evans, Social Worker
REACH
Jackson, MS

Aaron Lee
Jackson State University
Jackson, MS

Hill Williams, Jr.
Assistant Professor
Jackson State Universitiy
Jackson, MS

J. Elton Moore, Assoc. Professor
Mississippi State University

Willie H. Foster
Center Director
Independent Living

Richard Chiles
Jackson State University
Jackson, MS

John J. Simpson, Social Worker
Boswelll Retardation
Sanatorium, MS

Marilyn Adams
Crystal Springs, MS

Emma Peder
JSU- Jackson, MS

Barry Tice, Assistant Director
U.S. General Accounting Office
Washington, DC

Daryl Dunaway
Jackson Ctr. for Independent Living
Jackson, MS

LaWanda Smith-Cline, Teacher
Hazelhurst Elementary
Hazelhurst, MS

Shirley Jefferson, Student
Jackson State University
Jackson, MS

Hening Sherman, Director ICM
Bronx Psych. Ctr.
Bronx, NY

Dr. Kate Seelman
Research Specialist
National Council on Disability
Washington, DC

Linda Bond, Executive Director
The ARC/Mississippi
Jackson, MS

Denise Waldrep
Washington, DC

Shih-sung Wen
Psychology Department
Jackson State University
Jackson, MS

Robert L. Magee, Service Manager
Jackson State University
Jackson, MS

D. Free, Student
Jackson State Universiity
Jackson, MS

Maury Flack
Jackson, MS

Randy Turner
Construction Technologist
Jackson State University
Jackson, MS

Gwendolyn Lewis, Special Ed. Student
Jackson State University
Jackson, MS

Angela Anyann
Jackson, MS

Representatives from Jackson State University Student Body

Elizabeth Stewart
Clyde Speaks
Eric D. Williams
Bettie Martin
Gloria Wynn
Patty Jo Spiek
Beth Jeter
Debra Lee
Calvin Williams
Velma Bingham